



The Role of the family in cases of disputed medical decision making

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The Role of the Family in
Cases of
Disputed Medical Decision
Making

Carolyn Hayley Jane Hilder

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Abstract

This doctoral thesis considers the family's role in the process of making medical treatment decisions for one of its members.

Chapter 1 explores the meaning of family in the context of illness and disability. It is suggested that membership is not defined by biological or marital status but by interdependence, which also provides the moral and logical claim for a role of influence in treatment decisions.

Chapter 2 considers various ethical frameworks for development of an inclusive decision-making framework, using fictional case studies.

Chapter 3 examines the historical development of the legal framework for the resolution of treatment disputes revealing the 'invention' of a common law jurisdiction in respect of adults lacking capacity in order to meet perceived social need.

Chapter 4 examines the unifying concept of the various jurisdictions in respect of adults and children, namely the patient's 'best interests'. Decided cases are categorised by their principal issue to demonstrate that the judicial concept of best interests has been shaped by core values intrinsic to those issues, leaving consideration of the interdependence inherent in the family context side-lined. That such disregard is not a necessary corollary of the mechanisms adopted for decision-making is shown by comparison with later cases of paternity testing disputes.

Chapter 5 traces the last throes of the inherent jurisdiction through political engagement and the *Bournewood* litigation.

Finally chapter 6 assesses the provisions of the Mental Capacity Act 2005. It is argued that, although the statutory test of 'best interests' is susceptible to family-friendly considerations, the general authority limits involvement of families to trivial matters.

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Introduction

“Illness is the night-side of life, a more onerous citizenship.
Everyone who is born holds dual citizenship,
in the kingdom of the well and in the kingdom of the sick.”

Susan Sontag, New York Review of Books, 26th January 1978

Illness and disability are facts of life. At some point in our lifetime, we will all need medical attention. The need may be simple and transitory, complex and chronic, or anywhere in between but however and whenever it arises, decisions have to be taken about treatment. Sometimes, the appropriate response to a medical need is obvious to all concerned, so that treatment decisions may be taken easily and without controversy. Often, however, the ‘most appropriate’ treatment is a matter of subjective judgment, and therefore open to dispute. It may then be asked *how* such disputes are to be resolved, and in particular what is the family’s role in reaching resolution?

Medical treatment disputes usually involve doctors, whose decision-making will be governed by a professional code requiring compliance with a system of values, or ‘ethics’. A core value of medical ethics in Britain today is patient autonomy - the right of individuals to make decisions about their treatment being answerable only to themselves. According to this ethic, when treatment decisions have to be taken, doctors make informed recommendations but patients – and patients alone - choose whether to follow them or not.

It was not always so. Historically, the prevailing ethic had been one of professional beneficence: “doctor knows best”. However the world wars of the twentieth century brought a shift in cultural expectations. Health-care institutions replaced community doctors, and patients began to approach health-care more as

customers, with legal rights of redress. Medical malpractice cases increased,¹ and the courts affirmed the centrality of the patient in the language of rights of self-determination.² Autonomy came to be seen as an important break on the power of medics, and ultimately a bastion of liberty and democracy.³ Incidentally, it also came to operate as a restriction on the decision-making influence of patients' families.

Yet as a mechanism for making decisions and determining disputes, autonomy has its limitations. Most starkly, it does not assist where the patient in need of treatment is incapable of acting autonomously. Infants and children cannot make decisions on significant medical issues by reason of their immaturity, but adults too may never have developed autonomy because of innate disability, or they may lose the capacity they once had, temporarily or permanently, by reason of illness or accident.

More subtly, there are limitations in the vision of autonomy even as it applies to those of us who retain full mental faculties. People do not live as autonomous beings in splendid isolation from others. Almost universally, individuals are enmeshed in a web of relationships, most conveniently called 'family'. The legal concept of 'family' is undefined and loose, but the hallmark of family relationships – and what distinguishes 'family' members from 'carers' – is mutuality and interdependence. To be a member of a family is to be, at least to some extent, answerable to someone *other* than oneself.

In the limitations of autonomy, the relevance of families to medical treatment decisions is made apparent. Autonomy's dominance notwithstanding therefore the first question which this thesis seeks to answer is what *should* be the role of the family in the resolution of medical treatment disputes?

¹ For a fascinating study of the shifting cultural expectations of doctors and medicine, see Nelson & Nelson, *A Patient In The Family*. Although the study is of American healthcare systems, it offers insight into the British experience too.

² See for example Cardozo J's classic expression of the right of self-determination in *Schloendorff v. Society of New York Hospital* 105 NE 92; and in England, the affirmation of the need for consent in *AG's Ref (N0. 6)* [1981] QB 715

³ See Beauchamp & Childress' *Principles of Biomedical Ethics*, and the discussion of it in chapter 2 below; and the work of Ian Kennedy, including *Treat Me Right*.

To answer this question, chapter 1 explores how families both affect and are affected by medical treatment. Empirical evidence demonstrates that patients with good family support have better post-operative outcomes; and that one family member's illness has an adverse impact on the wellbeing of others. In the medical context, therefore, 'family' implies both benefit and responsibility, a challenge to the prevailing orthodoxy of autonomy, and therefore, it will be argued, a *moral* claim to influence in the decision-making process.

The importance of the family's claim for influence in the medical decision-making process is not, however, purely a moral one. There are significant *practical* implications to family support for medical treatment, which society cannot afford to jeopardise. Chapter 1 goes on to consider the statistics of health care economics, which make starkly obvious the dependence of the whole healthcare system on informal systems of patient support. Without family involvement in medical care, the NHS and social care budget would have to double. Any approach to decision-making which undermined the willingness of the family to continue current levels of patient support would have serious consequences for the taxation system, and so for us all – a very *practical* claim for family influence in the decision-making process.

Moreover, dependence on informal care structures has social ramifications beyond the strictly monetary. The time and effort involved in supporting an ill relative curtails earning capacity and social standing. Since family support of its weakest members is often an exaggerated expression of 'normal' family functioning, the burden of caring – and therefore the curtailment of income and standing - falls disproportionately on women. As a result, the labour market is distorted and the chances of realising aspirations of gender equality are circumscribed. If modern sociological objectives are to be realised, a balance must be struck between the interests of the treatment receiver and the treatment supporter, the patient and the family. That balance is most tangibly expressed in the role afforded to families in treatment decision-making. How society articulates that balance is a measure of its understanding and appreciation of the

contributions families make to our individual and collective welfare – a *sociological* claim for family influence.

Moral, practical and sociological claims may be compelling, but autonomy has a philosophical strength which also needs to be answered. Accordingly, this thesis goes on to ask what is the most appropriate ethical basis for medical decision-making, and what role does it suggest for the family?

Using fictional case studies, in chapter 2 the moral insights offered by various ethical codes⁴ are examined. Whilst it is recognised that each approach has its strengths, each also has its limitations. Ultimately it is concluded that the best prospect of securing optimal outcome for patients, families and society as a whole comes from a combination of approaches. The adoption of ethics of deontological constraint as a minimum standard, and care as an ideal, offers the possibility of medical decision-making informed from the perspectives of *both* patient and family. Such a combined approach does not offer simple answers to complex issues, but it allows a place for all interests, and makes clear the stakes at play.

With aspiration and ethic identified, considerations can next turn to practical experience of treatment dispute resolution. What is the role historically afforded in law to the family of patients in respect of whom a decision has to be taken?

To answer this question, recourse must be had to decided case law. Autonomy and confidentiality considerations combined ensure that treatment disputes are most visibly played out in the courts (and therefore available for present scrutiny) in the context of actual or anticipated patient incapacity. Chapter 3 therefore examines the historical development of a court jurisdiction to determine such cases and its incidental shaping of the family role. In respect of minors, the judicial approach to parental authority is analysed, from *parens patriae* to the Children Act 1989. In respect of adult patients, common law powers up to the enactment of the Mental Capacity Act 2005 are examined. The inherent

⁴ Specifically, casuistry, consequentialism, deontology, virtue theory, care and principlism.

jurisdiction – a declaratory procedure of the High Court - is shown to be essentially an invention of the judges, created to fill an unintended lacuna in the law after successive Mental Health Acts, and then developed piecemeal, in response to the accidental demands of individual cases and without rigorous ethical foundation.

How as it then that the family role was shaped? What considerations nudged family interests into their current position? Whatever their historical differences, the jurisdictions in respect of both children and adults are bound together by the common concept of the patient's 'best interest'. Grouping decided cases thematically offers insights into the judicial understanding of this concept and how it has shaped the decision-making role afforded to families. Chapter 4 identifies key issues of sterilisation, life-saving treatment, borderline capacity and religion and argues that they illuminate certain core values by which judges navigate *all* disputes, leading to a systematised failure to recognise family interdependence. The role left to families in the determination of medical treatment disputes is shown to be marginal and unsatisfactory, both in ethics and in practice.

However, the same thematic analysis of cases also reveals that the judicial approach to 'best interests' demonstrates inherent adaptability. It is pertinent to ask next if the medical decision-making role historically ascribed to the family in law could be brought more in line with our ideal within the established legal framework?

Chapter 4 suggests that the broadening understanding of interests and the adoption of a 'balancing exercise' to guide judicial determinations make it possible to envisage for families a fairer and more influential role in the decision-making process, without sacrificing any of the values central to judicial determinations. Recognition even of the family's competing interests is not incompatible with the decision-making mechanism adopted under the inherent jurisdiction of the courts, and need not imply any loss of focus on the patient. By way of illustration, chapter 4 concludes by drawing comparison with the legal approach to paternity testing disputes. Originally itself a medical procedure,

experienced by the subject as very similar to immunisation, modern resolutions of paternity testing disputes offer a model of how the inherent jurisdiction *could* have continued to develop to meet our ethical ideal.

However time, and the law, do not stand still. Common law has latterly been superseded by statute, namely the Mental Capacity Act 2005. Given the expense and effort involved in legislation, it is pertinent to ask how such change come about, and why? Chapter 5 explores the pressures leading to legal reform. Even as common law powers in respect of adults were discovered and developed, there were calls – led by the judiciary – for statutory reform; and social realities had already compelled political engagement when the protracted *Bournewood* litigation exposed the common law approach to a different jurisprudence. Subjection of the inherent jurisdiction to the rigours of European human rights legislation, *Bournewood* itself, and the judicial determinations made in its wake both foreshadowed the passing of legislation and informed many of its provisions.

When the Mental Capacity Act 2005 came into force in April and October 2007, it did not extinguish the inherent jurisdiction, but supplanted it. Chapter 6 considers how the Act develops the key concepts of the common law, and in particular how it conceives of families. Is the family role in medical decision-making changed? Is it any closer to our ideal? Is there any hope for improvement in the future?

Much hailed for its patient-focus, the statutory checklist of ‘best interests’ is nonetheless susceptible to family-friendly interpretation. In everyday matters where the family assumes the role of carer, the general authority operates to extend them an unprecedented warrant for decision-making. However, in more significant issues, that same general authority *excludes* the family from any decisive role. The overall effect of the legislation, it is concluded, will be to leave families in medical treatment disputes in much the same position as they were under the inherent jurisdiction, with too little recognition to meet our ethical benchmark. A long-awaited opportunity to reshape the role of the family in medical decision-making has been sadly missed.

Chapter 1

The Concept of ‘Family’ and Why It Matters In Medical Decision-Making

This chapter considers what is meant by ‘family’, and why families are relevant to medical treatment disputes. Family support improves the medical prognosis for patients; but a patient in the family can be a strain on family resources. Simple fairness requires that the family’s contribution towards better medical outcomes, and the penalties paid for caring, should afford families some recognition in the legal process of resolving treatment disputes.

It is a notion both common place and poetic that people do not live in isolation:

“No man is an Island, entire of it self; every man is a piece of the Continent, a part of the main; ...”⁵

Even whilst they are patients, people are also partners, parents, daughters and sons, neighbours and colleagues. We live our lives enmeshed in a network of social relationships, where burdens and benefits flow in both directions. The people who make up our primary social network, from whom we draw our greatest benefits and for whom we accept the heaviest obligations, we usually call our ‘family’.

The Social Concept of ‘Family’

In British society at the beginning of the 21st century, ‘the family’ is a loose concept which eschews precision and repels attempts at definition. As the *concise* Oxford dictionary puts it:

⁵ John Donne, *Devotions upon Emergent Occasions*

family **1.** a set of parents and children or of relations, living together or not. **2a** the members of a household, esp. parents and their children. **b** a person's children. **C** (*attrib.*) serving the needs of families (*family butcher*). **3a** all the descendants of a common ancestor; a house, a lineage. **b** a race or group of peoples from a common stock. **4** all the languages ultimately derived from a particular early language, regarded as a group. **5** a group of persons or nations united by political or religious ties. **6** a group of objects distinguished by common features.

In everyday conversation, we talk of 'family' in many different ways, drawing understanding from the context. In a given situation, most people are able to list the people who make up their 'family', even if they cannot identify a unifying characteristic which makes them so. So when a woman proposes 'starting a family', her partner thinks of children; when she proposes 'having a family gathering', he prepares himself for parents, siblings, cousins, Uncle Tom Cobbley and all; and when they draw up their 'family tree', he looks to ancestors and descendants, the longer dead and wider spread the better.

Who do we mean when we talk of our 'family' in the context of medical decision-making? Those with a legal connection to us, such as marriage, civil partnership or adoption, may be one starting point, for anybody who has chosen to adopt such a legal status has a clear interest in the other's well-being. Biological connection may be another for at some point in our lives we usually live most intimately with those who share our genes. Moreover anybody sharing genetic heritage has a clear interest in some types of medical condition such as haemophilia or certain types of cancer, where there may be an inherited defect or tendency. Yet neither biological nor legal connection is sufficient. Even added together, these relationships exclude those who may be closest, such as a cohabitant or friend; whilst those who share a gene pool or a certificate may now be distant, estranged or completely unknown.

When illness clouds the horizon, a patient is most likely to ask for help from those who are most closely connected on an emotional level – the people she

cares about and who care about her - on an ongoing and voluntary basis, whatever their biological or legal status. Think of the family as a novel⁶ with the patient's story as one chapter. It then becomes more apparent who are the significant characters. The caring and committed connection that comes with shared lives and mutual dependency is sufficient to bring anyone into the family fold as most people see it, irrespective of biological or legal status.⁷ For the purposes of this thesis then, that is the notion of 'family' which I adopt.

At first consideration, this understanding of 'family' calls to mind the modern preoccupation with 'carers'. Since feminist academics began to discuss an ethic of care in the early 1980s, carers' pressure groups have been established and developed into vocal lobbyists; government policy depends on 'carers' meeting the needs of vulnerable people whom the state wishes not to place in institutions; and Jonathan Herring has recently begun the call of the legal academy for their recognition.⁸

However, not all 'caring' is the same. The government definition refers, in broad terms, to people who "look after a relative or friend who needs support because of age, physical or learning disability or illness, including mental illness"⁹. However those who champion caring are usually¹⁰ careful to distinguish 'carers' from 'paid carers', in recognition of the reality that care which is given in a domestic setting of interdependence is somehow intrinsically different from care which is performed for a wage¹¹. A neighbour who volunteers to collect

⁶ As suggested by Nelson & Nelson, *A Patient In The Family* at p107. The analogy of the novel also makes it clear that significant characters cannot be overlooked simply because others dislike them, disagree with them, or disapprove of them.

⁷ Others have taken a similarly broad view. Buchanan and Brock consider that "family is whomever the individual is most closely associated with": *Deciding for Others: The Ethics of Surrogate Decision-Making*, Cambridge University Press 1999.

⁸ See 'Where are the Carers in Healthcare Law and Ethics?' [2007] Legal Studies 51, and 'The Place of Carers', a paper given at UCL Law & Bioethics Conference, soon to be published in book form (ed. Freeman).

⁹ Department of Health, *Caring About Carers* (London: Dept. Of Health, 2005).

¹⁰ For example the Carers UK definition in *Facts About Carers* and most relevant legislation. But it is not universal: see for example 'Paid Emotional Care: Organizational Forms That encourage Nurturance', Francesca M. Cancian in *Care Work* ed. Madonna Harrington Meyer at pp136 – 149.

¹¹ I agree that it is different, but not simply by reason of receiving payment. Such an argument undermines the progress that has been made in provision by the welfare state for payments to family carers.

shopping for a sick neighbour is *caring* and is included in the consideration, even though the degree of commitment and involvement is quite small: a community nurse is not, even though she works eight hour shifts. Most significantly for present purposes, parents caring for able-bodied children¹² in the ordinary way of childhood are not generally counted as ‘carers’.

So, the understanding of ‘family’ on which I rely implies both more and less than caring. What unites the emotionally connected and the biologically connected as ‘family’ in the context of medical decisions – and also what really distinguishes them from paid carers - is that when the decision has to be made, in some sense they are inextricably part of it. The decision will impact upon *their* lives too.¹³ Whether an elderly Alzheimer’s patient receives Aricept or not impacts upon the nature and degree of care their spouse or adult child will need to provide¹⁴, and therefore the ability of the spouse or adult child to do other things like earn a living. In such a situation, it matters little whether we define the third party as a family member or as a carer – the impact is the same. However, for other medical issues, the trajectory of impact may be different. The diagnosis of a mutative gene, for example, impacts on the patient’s daughter and her life plans, whether she is local, loving and caring or distant, estranged and *uncaring*.

¹² See for example the definition of carers in Carers UK *Facts About Carers* (London: Carers UK 2005). Herring’s consideration adopts this protocol too – see ‘Where are the Carers in Healthcare Law and Ethics?’ 27 *Legal Studies* 51 at p52. Herring also points out that, although a normal reading of the government’s definition would suggest that parents are included, this cannot have been the intention, as can be seen by the report’s citation of the number of carers as only 5.2 million. That citation also gives a clue as to *why* parents of normal able-bodied children are not included: there are just too many of them. Normal parenthood is these days, in theory at least, both a matter of choice and an ordinary feature of adult life – not something to attract special policy consideration or benefit.

¹³ This may be said of treatment decisions, whether they are disputed or not, but accord implies consent, whereas dispute suggests that a decision taken *against* family preference will be experienced as an imposition, and therefore require more careful justification – hence the focus of this work of the resolution of medical treatment *disputes*.

¹⁴ The judgment of Dobbs J in the case of *Eisai Ltd. v. The National Institute for Health and Clinical Excellence* [2007] EWHC 1941 refers at paragraph 123 to “some 4000 responses to Alzheimer’s Society and 7000 to NICE consultation” all giving evidence from carers about the beneficial effects of the drug for them. (The Alzheimer’s Society did not pursue intervention in the Court of Appeal but filed evidence making it clear that it supported the concerns successfully raised there by the Appellant: *Eisai Ltd. v. The National Institute for Health and Clinical Excellence* [2008] EWCA 438 per Richards LJ at paragraph 3.)

It is true that medical decisions in respect of a particular patient may also have an impact on the lives of non-family members. The paid carer may be called upon to perform different physical tasks, or to call more or less frequently; and the neighbour may be asked more or less frequently to perform out-of-hours favours. But there is a difference of kind and degree. The paid carer can go home at the end of her shift, and the neighbour may close her front door. With the emotional connection of family caring or the biological connection of shared genetics, there is an additional burden of responsibility that comes simply by virtue of that connection¹⁵ and lasts twenty-four hours a day.

So the terms ‘family’ and ‘carer’ are not co-extensive and interchangeable. For convenience, we may sometimes use ‘carer’ as a short-hand for one type of family member, but it is the interdependence – the connectedness - of family members which provides the distinguishing feature which is the basis for consideration of their role in medical decision-making, not simply the avenue of its expression.

The Legal Concept of ‘Family’

The law adopts a similarly pragmatic approach. The legal concept of ‘family’ relies on the common understanding of everyday language. There are no statutory definitions for lawyers to pore over and deconstruct. ‘Family’ is not a legal term of art, but an ordinary word for communication. When used in a legal context, it is the judges who determine its meaning, according to their perception of prevailing social conditions.¹⁶

¹⁵ As Draper & Sorrell put it, “The nearest and dearest are under some sort of obligation to pick up the pieces if the mishaps are serious...because belonging to a family is often supposed to be a necessary last line of defence against a sometimes hostile world of strangers. ...the devotion of friends and relations can be morally necessary, even if the people who depend on it do not always deserve it.”: ‘Patients’ Responsibilities in Medical Ethics’ (2002) *Bioethics* 335 at 348-9.

¹⁶ MDA Freeman argues that the relationship between social conditions and legal recognition is not really so one-way. “There is clear evidence that not only does the law serve to reproduce social order, but it actually in part constitutes and defines that order...The legal form is one of the main modalities of social practice through which actual relationships embodying gender stratification have been expressed.” *Towards a Critical Theory of Family Law* 1985 *CLP* 153 at 158

Generally in law ‘family’ “connotes essentially some grouping, usually of persons, who are connected with each other by some particular kind of bond,”¹⁷ but the kinds of bond which judges favour change with the times. What counts as ‘family’ in law now, may not have done ten years ago and what does not count yet, may in time.

Historically, the courts have recognized ‘family’ in bonds of marriage (including “in-law” and “step” relationships¹⁸) and consanguinity. The archetypal ‘family’ is a married couple and the children of their union. Modern social conditions have dissolved the *necessity* for either marriage or genetic descendancy,¹⁹ but they have not brought about their extinction. Where there is marriage and bloodline, the traditional recognition will be readily afforded.

However, as we approach the end of the twenty-first century’s first decade, the law’s understanding of ‘family’ has developed, so that it is no longer constrained by such legal status and lineage. Other types of bond are accepted as having the potential to constitute a ‘family’. Marriage and adoption no longer carry the automatic privilege over cohabitation and parenthood that they once did and divorce, the breakdown of marriage, is no longer necessarily the end of family life.²⁰ As Dewar puts it, “instead, the law now offers a variety of lenses through which family relations may be understood.”²¹

Such development has been driven by general social reality. According to the 2007 British Household Survey, 14% of men and 13 % of women aged between 16 and 59 were cohabiting, and 44.3% of all live births were to unmarried

¹⁷ Per Lord Clyde in *Fitzpatrick v. Sterling Housing Association Ltd* [2001] 1 AC 27 at p48.

¹⁸ *Jones v. Whitehill* [1950] 2 KB 204: a niece-in-law was entitled to succeed to property as ‘family’.

¹⁹ In the sense that cohabiting adults with a baby created by anonymous gamete donors and surrogacy can function as, and look to the uninformed exactly the same as, the family archetype.

²⁰ “Separation and divorce was once the mark of the end of family life, and policy was to encourage the former partners to go on to make new families. It seems that now separation or divorce is seen, if not as a normal part of changing family life, at least as an unremarkable one.” Alison Diduck, ‘Shifting Familiarity’ 58 CLP 235 at 238

²¹ John Dewar, ‘Family Law and its Discontents’, *International Journal of Law, Policy and the Family* 14 (2000) 59-85 at p62.

mothers. Adult relationships outside marriage are now so common, and so uncontroversial to the majority populace, that a legal concept of 'family' which insisted on matrimony would fly in the face of wider social values, such as equality and equal treatment,²² and would simply look silly.

A 'conventional' heterosexual cohabiting relationship - a lifestyle of marriage in all but the certificate - is now readily recognised in law as a 'family'.²³ Other types of adult relationship are increasingly accepted in wider society too and the courts are catching up. The House of Lords recognised that a partnership of two men amounted to 'family' in the landmark case of *Fitzpatrick v. Sterling Housing Association Ltd.*²⁴ This was a major step forward in the development of the legal concept of 'family' but at the time it was actually the smaller of two possible steps. Homosexual partners were denied the status of 'spouse'. With the passing of the Civil Partnership Act 2004, this rapidly became untenable,²⁵ and a differently constituted House subsequently corrected it in the case of *Ghaidan v. Godin-Mendoza*.²⁶ Other recent statutes, like the Human Tissue Act 2004,²⁷ have been drafted to reflect the modern view from the outset.

Having gone beyond those forms of relationship which provide the ready identification of a certificate of legal status, if 'family' is to retain any special significance at all, judges have had to find other ways to distinguish between those adult partnerships which fit the model, and those which do not. In so doing, judges have been compelled to formulate what constitutes the 'essence' of family

²² Since conjugality "is not an accurate marker of the qualitative attributes of personal adult relationships that are relevant to practical legislative [and policy] objectives", per the Law Commission of Canada, in 'Beyond Conjugality: Recognising and Supporting Close Personal Adult Relationships' (Ottawa: Law Commission of Canada 2002).

²³ For example *Hawes v. Evenden* [1953] 1 WLR 1169, *Dyson Holdings Ltd. v Fox* [1976] QB 503

²⁴ [2001] 1 AC 27

²⁵ When the state has afforded status recognition to a homosexual couple, the only distinction between them and a married heterosexual couple is the mechanics of intercourse, which is irrelevant to any common understanding of 'family'.

²⁶ [2004] UKHL 30

²⁷ s 54(8): 'For the purposes of this Act, . . . a person is another's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship.'

in law.²⁸ They found that essence in the *substance* of the relationship, extending recognition to partnerships of commitment, withholding it from the transient:

“...there should be a degree of mutual interdependence, of the sharing of lives, of caring and love, of commitment and support.”²⁹

“Essentially the bond must be one of love and affection, not of a casual or transitory nature, but in a relationship which is permanent or at least intended to be so. As a result of that personal attachment to each other, other characteristics will follow, such as readiness to support each other emotionally and financially, to care for and look after the other in times of need, and to provide a companionship in which mutual interests and activities can be shared and enjoyed together.”³⁰

“...love, trust, confidence, mutual dependence and unconstrained social intercourse...are the essence of family life.”³¹

Such descriptions read rather like a Mills and Boon plot synopsis, portraying an idealisation of relationships which most happy families would admit is not always attained. Reality creeps in with judicial recognition that not all these characteristics have to be present in every case. There must simply be *enough* of them to justify the application of the descriptive term ‘family’.³²

Widening the legal understanding of how a ‘family’ may be made up does not, however, imply *automatic* legal recognition of the new constructions. There is a privilege remaining to the legally married, in that their certificated status affords them the *presumption* of being ‘family’; whereas de facto partners must bring

²⁸ In *Fitzpatrick* the House of Lords was concerned with the construction of a statute passed in 1920. Instead of looking to what constituted ‘family’ when the Act was drafted, the majority decision looked to what characterised it. It was then possible to ask if the modern Plaintiff (whose domestic arrangements would certainly not have been recognised in 1920, indeed whose lifestyle would have been criminal then) fulfilled that essence in the social conditions of 1999.

²⁹ Per Lord Slynn of Hadley, in *Fitzpatrick* at p38.

³⁰ Per Lord Clyde, in *Fitzpatrick* at p51.

³¹ Per Lord Bingham in *Secretary of State for Work & Pensions v. M* [2006] UKHL 11 at p[11]

³² Per Lord Hutton (dissenting) in *Fitzpatrick* at p73

evidence to establish that they qualify.³³ A presumption may not sound like much recompense for the cost of a wedding ceremony, but in terms of convenience, it is priceless. When a recently bereaved partner is trying to claim a pension, it is much easier to produce a marriage certificate than to compile satisfactory evidence of shared living arrangements to satisfy a reluctant provider. Moreover, both domestic and European Court of Justice judgments suggest that this presumption is not easily rebutted – the status of family gained by marriage will not be lost simply by separation, but subsists at least until formal dissolution.³⁴ The feckless and unloving spouse is still ‘family’ when his cohabiting counterpart may not be.

However, to date, judicial recognition of ‘the essence’ of family has been quasi-marital. The courts have adopted a fairly narrow interpretation of cohabitation. Where it is claimed to be the basis of ‘family’ life, cohabitation has been narrowly interpreted. Defined in a decidedly contemporary context, cohabitation implies the need for a sexual element in the relationship. Merely living together on a domestically sharing but platonic basis misses the mark,³⁵ as does the relationship between a grown-up ‘child’ and elderly parents.³⁶ The law’s notion of ‘family’ between adults has not so much widened, as simply dropped the requirement of a marriage certificate for entry.

The Context of Medical Decision-Making: In the context of disputed medical treatment, a quasi-marital understanding of ‘family’ is inappropriately narrow. As we have seen, when people are ill or disabled, the quasi-marital social unit is important, but not sufficient. Today, the reality of an ageing population is that

³³ Per Lord Slynn in *Fitzpatrick* at p38.

³⁴ Eg *Diatta v. Land Berlin* [1986] 2 CMLR 164 – a married couple who lived in separate houses pending finalisation of their divorce still qualified under the free movement provisions for as long as the legal marriage persisted. And *R v. IAT and Singh ex p Sec St for the Home Dept* [1992] ECR1 4265 – an Indian national had married a British citizen and travelled with her to work in Germany. Notwithstanding that the Decree Nisi of their divorce was already pronounced, he was able to benefit from Community Law protection until the marriage was finally dissolved.

³⁵ See the remarks of Russell LJ in *Ross v. Collins* [19645] 1 WLR 425, and the decision of the Court of Appeal in *Joram Developments Ltd. v. Sharratt* [1979] 1 WLR 928, from which the House of Lords in *Fitzpatrick* in 2001 expressed no need to depart (see Lord Nicholls at p44).

³⁶ *C v. UK Dec 3.7.92 DR 73*, 27: where the European court rejected a claim to ‘family life’ encompassing a 26 year old daughter, married and employed, and her financially independent parents.

adult children are often shouldering responsibilities for increasingly dependent parents. Each of them – parent and child(ren) - may be fighting very hard to retain their independence of finance and housing, such as would preclude them from the legal concept of family expounded in the case law so far, but they are giving and receiving care and support, not because caring is a vocation of one and a purchase of the other, but *because they are family*.

Moreover, it is not just an intergenerational concept of family that is needed. The grown-up children who shoulder the practical burdens of caring for parental infirmity rely on their siblings to take a turn; on their partners, and even on their *former* partners, to make it possible for them to give time to parental care by looking after the children. A whole network of familial relations is involved. Failure to recognize the ‘family’ here would leave the law out of step with common experience.

There are signs that law and legal processes are both capable of encompassing a much wider concept of family – the concept which is central to present considerations - and are indeed moving that way. Since context is relevant to legal interpretation, just as it is in common usage of the term ‘family’, it is significant that the leading cases of judicial interpretation of ‘family’ have so far all been concerned with economic entitlements or liabilities,³⁷ in respect of which there may be public policy reasons for a narrow interpretation. By contrast, in medical care, the public policy is to maximize informal, ‘family’-type, support systems. Therefore in the context of medical treatment decisions, the public policy pressure is towards an *inclusive* view of ‘family’. Helen Stalford has identified precisely such a divergence between the interpretation of the family adopted by the European Union, based on economic considerations, and that adopted by Strasbourg, based on humanitarian considerations.³⁸

³⁷ *Fitzpatrick* [2001] 1 AC 27 and *Ghaidon* [2004] UKHL 30 were concerned with succession to a tenancy; and *M* [2006] UKHL 11 was concerned with liability under the Child Support Act.

³⁸ ‘Concepts of Family under EU Law – lessons from the ECHR’ (2002) *International Journal of Law, Policy & the Family*

The mechanism by which UK domestic law has been able to develop its concept of ‘family’ so far is instructive here. In *Fitzpatrick*, the courts were able to apply a modern view of a family’s constituent persons to statutes drafted in very much more restricted social conditions by adopting the device of looking to the characteristic elements of ‘family’. This reasoning explains why the dissenters in *Fitzpatrick* were wrong to protest that if Parliament had intended to include homosexual partners the statutory amendments of 1988³⁹ would have been differently phrased. In 1988, social conditions had not yet extended to the recognition of homosexual partnerships as family units, whereas by 1999 they had. It also explains why *M*⁴⁰ lost her claim in respect of discriminatory child support calculations. Although by 2006 the calculation differential would have been discriminatory, in the relevant period (ending in 2001) recognition of homosexual relationships was so new as to be within the permitted ‘margin of appreciation’.

By the same mechanism, the concept of ‘family’ applied by the courts in cases of disputed medical decisions today should embrace an expansive view of constituent persons. Current methods of medical care delivery suggest that financial and housing independence are not relevant to the expectation of, or necessity for, family support; that social intercourse does not have to be unlimited, and sexual intimacy has nothing to do with it. If ‘care in the community’ in reality means ‘care by one’s family’ then that family deserves legal recognition, whether or not it is quasi-marital.

If the legal concept of family were to acknowledge the wider network involved in medical care as suggested, consistency would require a reinterpretation of old decisions. If the 24 year old man and the 75 year old woman in *Joram*⁴¹ were living the essence of modern family life, why should they not be afforded recognition too? The possibility of reinterpretation as social conditions demand is a feature, indeed a strength, of the common law. Finding a ‘family’ relationship if there were to be a medical treatment dispute today involving the people of

³⁹ Which effectively equated cohabiting heterosexual couples with spouses.

⁴⁰ *Secretary of State for Work & Pensions v. M* [2006] UKHL 11

⁴¹ *Joram Developments Ltd v. Sharratt* [1979] 1 WLR 928.

Joram would be no more inconceivable than was *Ghaidan's* extension of *Fitzpatrick*. In the current social climate, where legal ties can be undone, and de facto relationships feature somewhere in everybody's lives, most people would have no difficulty seeing the essence of 'family' there.

Lord Hutton (one of the dissenting minority in *Fitzpatrick*) would protest that this goes too far; that if a marital or biological bond is not prerequisite, then why not extend the meaning of 'family' to include "two elderly spinsters who live together for mutual support and companionship in old age"?⁴² The only sensible response to that question is 'why not indeed?' If their relationship has enough of the characteristics previously identified as hallmarks of family life, the absence of sexual relations should be as irrelevant as the mechanics.

Such an inclusive concept of 'family' would be consistent with other recent developments in the fields of family and medical law. Although the special status of grandparents was removed by the Children Act 1989, the government has since recognised anew the significant role grandparents often play in supporting younger generations, targeting them for specific initiatives, and even considering paying them to provide childcare.⁴³ Similarly, the Mental Capacity Act 2005 specifies the need to take into account the views of carers and others with an interest in the welfare of an incapacitated adult for whom decisions, including medical ones, need to be taken.⁴⁴ Furthermore, the parenthood provisions of the Human Fertilisation and Embryology Act 2008 allow the second legal parent to be *anyone* except those within the incest prohibitions.⁴⁵

⁴² *Fitzpatrick* at p64

⁴³ See G. Douglas & N. Ferguson, 'The role of grandparents in divorced families' (2003) 17 *International Journal of Law, Policy & the Family*

⁴⁴ For a full consideration of the implications of the Mental Capacity Act on the role of families where treatment disputes arise, see chapter 6 hereafter.

⁴⁵ The potential second parent is excluded if 'within prohibited degrees of relationship' by s37(1) if he is a man, and by s44(1)(e) if she is a woman. The 'prohibited degrees of relationship' are defined in s58(2) as parent, grandparent, sister, brother, uncle or aunt. Sally Sheldon (in an article awaiting publication) points out that this restriction perpetuates the limitation of parenthood to those for whom sexual relations are at least permissible. This is true, but it does not undermine the argument that the second parenthood provisions support a concept of 'family' wider than that based on sexual bonds. People within the prohibited degrees are not permitted a sexual relationship precisely because they are already 'family'. The restriction is aimed at maintaining not just the prevention of undesirable genetic inheritances, but also the social taboos which underpin it.

The second parenthood provisions merit some reflection because they have, at a stroke, expanded non-genetic *parenthood* to include non-sexual bonds, including simple friendship. The intention of the Act was undoubtedly to put same sex couples and unmarried opposite sex couples in the same position as married couples,⁴⁶ which suggests perpetuation of the old quasi-marital concept of families. However, in order to achieve its objective, the wording of the statute has opened the gates to a much wider basis for family relations. The parenthood provisions contain no requirement that parents should live together, or provide mutual support, financial or otherwise.

If two *friends* may become the legal ‘parents’ of a child, the adult relationship forged around the child must fall into the legal concept of ‘family’, even if they maintain independent households and celibate lifestyles, otherwise the law would be granting recognition with one hand, only to take it away with the other. Parenting is the *fons et origo* of the very institution of matrimony, so it must contain the ‘essence’ of family life.

Clearly, to the child whose parentage is determined pursuant to the Human Fertilisation and Embryology Act, both parents will be ‘family’: if the child has medical problems, both parents would have the power to consent to treatment. Could it nonetheless be argued that two co-parents whose relationship does not resemble the quasi-marital should nonetheless be outside the concept of ‘family’ *vis-à-vis each other*? If one of the parents has medical problems, should the co-parent not form part of her ‘family’ if their relationship has never included physical intimacy?

Quite apart from the inherent evidential difficulties, such a construction of ‘family’ would be unacceptably strained. Even if the adults have co-parented at a distance, maintaining separate homes and finances, each is affected by the illness of the other, through their shared responsibility for the child. They are, at the

⁴⁶ See the statute’s Explanatory Note, para 16.

very least, analogous to divorced parents – and we have seen already that divorce is no longer necessarily viewed as the end of family life.

Affording recognition to families in this way does not undermine the archetypal family. Rather, it demonstrates the powerful hold of the essence of that archetype, even on people for whom achieving it would be impossible. As Fineman and Diduck both argue,⁴⁷ the more that those outside the ambit of ‘family’ want to be inside it, the greater the social hold of the institution – which should give the law the incentive to expand it. Undoubtedly, a genetic or legal link is important to many people, but legal interpretation is not a competition: the challenge is not whether to prefer social development over traditional status, but how to frame laws which give adequate support to practical reality.⁴⁸

Recognition of the practical reality of family life in the context of disputed medical decisions does not seem too much to ask when it is remembered that other areas of law *expect* the family to influence the behaviour of its members. Statutes like the Crime & Disorder Act 1998 and the Antisocial Behaviour Act 2002, which ascribe legal responsibility to parents for their children’s criminal behaviour, and provide for parenting orders and parenting contracts as part of a young person’s sentence, have extended responsibility for one person’s behaviour to other members of his family, but their significance is more than in the placing of blame. Such provisions indicate a subtle shift in the law’s perception of individuals and families: the criminal minor is

“no longer an autonomous free agent who can be held individually accountable for his or her own actions. On the one hand children are deemed, for the purposes of founding criminal liability, to be legally competent as autonomous individuals, but on the other they are now familialised: their identity, their legal subjectivity, includes being part

⁴⁷ MA Fineman, ‘The Autonomy Myth: A Theory of Dependency’ ; Alison Diduck, ‘Shifting Familiarities’ 58 CLP 235

⁴⁸ As Bainham puts it, ‘how to define laws which give adequate weight to biological truth alongside adequate support for those who are actually raising a child’ (2000) ‘Family Rights in the Next Millennium’ 53 CLP 471-503 at 486.

of a family which must therefore, accept some responsibility for their criminal behaviour.”⁴⁹

If the law is capable of demanding responsibility where there is family, surely it is capable of recognising family where there is already responsibility.

Why The Family is Important In Medical Decision-Making

Understanding the notion of ‘family’ is only relevant to medical decision-making if the family has an effect on medical considerations, or is itself affected by medical decisions. In reality, the family is relevant in both respects.

The impact of the family: From the connection previously identified as the hallmark of ‘family’ comes a unique familiarity with the patient and their experience of the medical condition. Medical experts and decision-makers would do well to plunder such knowledge in pursuit of the best possible outcome for the patient,⁵⁰ but the impact of families on health care is not limited to the provision of information.

For the individual patient, it is self-evident that the involvement of a supportive family ameliorates an otherwise undesirable experience: illness or disability is seldom any fun, but it is even less so if it has to be faced alone. A study by Bothelho⁵¹ found that the majority of patients prefer to have a family member with them in the consulting room and it is standard practice to discharge

⁴⁹ Alison Diduck, ‘Shifting Familiarity’ 58 CLP 235 at 243

⁵⁰ ‘Eight Hours a Day and Taken for Granted?’ , a report of The Princess Royal Trust, cites at p23 the case study of “Margaret Seymour, 60..[who] cares for her son 15 hours a day. Colin, 26, is severely disabled...Having cared for her son all his life, Margaret is able to tell when he is unwell. Nine years ago she decided her son needed urgent medical attention. “I took him to hospital and told the doctors he was ill but no one would listen to me. When they finally did blood tests, the results were so extreme that they thought the samples had been switched.” Margaret now has a letter from her doctor stating that if she believes her son needs medical attention, hospital staff must listen to her....”

⁵¹ R. Botelho et al ‘Family Involvement in Routine Health Care: A Survey of Patients’ Behaviours and Preferences’ (1996) 42 J Family Practice 572.

someone from hospital earlier if there is someone at home to care for them. The moral support and practical assistance which families offer makes it possible for patients to cope with the unaccustomed demands of illness or disability.

Beyond moral support and practical assistance, families also serve to 'domesticate' illness. As Nelson and Nelson⁵² point out, when illness and injury alienate us from ourselves, domestic intimates provide the fixed and familiar point of reference which enables us to preserve a sense of self. Moreover, there are indications that the support of a family network directly improves medical prognosis. Several studies⁵³ across a range of medical conditions, from cancer to strokes, conclude that family social support is a significant factor in patient recovery.

For society at large, there are also clear beneficial effects of family involvement with individuals. Politicians fall over themselves to extol the virtues of the family unit, because families are the primary building blocks of a stable society – the community's nursery. Infants who are nurtured in a caring family learn habits of tolerance and active involvement which are the foundations for participation in democracy and public life. Families are where citizens are created, and the support they offer in times of sickness or disability is a clear example of citizenship training.

The numbers of families involved in providing care for sick and disabled members are eye-watering. Statistics are not gathered for every act of supporting medical needs, but one circumstance in particular currently preoccupies policy makers: the care of the elderly and infirm. Adult children now provide a greater amount of care, and more difficult care, to their parents and parents-in-law and

⁵² *The Patient In The Family* at p 45-46 : "...when we can no longer take for granted the smooth functioning of our bodies...we can turn to our families for orientation to our new reality. ... When the illness is chronic, family members do the same thing over time, quelling the effect of self-alienation by the very ordinariness of their personalities."

⁵³ See for example J. Spiegel, 'Psychosocial Intervention in Cancer' [1993] *Journal of the National Cancer Institute* 85 1198, F. Fawzey, 'Psychosocial Interventions for Patients With Cancer: What Works and What Doesn't' [1999] *European Journal of Cancer* vol 35 issue 11 page 1559, and Tsouna-Hadjis et al 'First-Stroke Recovery Process: The Role of Family Social Support'[2000] *Archives of Physical Medicine and Rehabilitation* vol 81, issue 7, page 881.

for far longer, than ever before in history.⁵⁴ With an aging population, the burden of need is high already and set to rise inexorably. There are currently 400 000 families providing intensive support to their disabled parents, with the need projected to rise to 600 000 by 2041.⁵⁵ Such numbers give a clear impression of the scale of citizenship going on in families.

Tronto points out⁵⁶ that family interdependence has implications for society beyond the moulding of individual citizens. What starts as an aspect of intimate relationships has also an existence and a set of consequences at a macro-level. Family support structures prompt a response from the state in the shape of organisations, markets and government. When the welfare state responds to the needs associated with caring⁵⁷, it thereby alters the division of labour, cost and responsibility within the state, market, not-for-profit sector and family providers. Relations of gender and generation are thus ‘engineered’ as by-products of public policy⁵⁸ with profound social consequence. In particular, an age-old belief that caring is ‘women’s work’ is reinforced, and the quest for equality of opportunity for all is undermined.

However society responds, it is not necessarily driven by altruistic motives. It is a matter of trite observation that the way in which any society cares for its weak and vulnerable members is a measure of its civilisation. It is less trite to observe that families make civilisation cheap. Without family care, many of the sick and disabled would be dependent on state provision. Figures quoted for the additional costs of such care vary, but whichever is preferred, the amounts involved are staggering: in 1998 the Institute of Actuaries estimated an additional cost of £34

⁵⁴ See Daniel Callahan, *Setting Limits: Medical Goals in an Ageing Society* at p21; and Elaine M. Brody, *Women in the Middle: Their Parent-Care Years* at pp6-9.

⁵⁵ L Pickard, ‘Informal care for Older People Provided By Their Adult Children’ (2008) PSSRU Discussion paper 2515.

⁵⁶ JC Tronto, ‘Moral Boundaries: A Political Argument for an Ethic of Care’ (1993) London: Routledge

⁵⁷ There are currently a number of state benefits and allowances available to both carers and the cared-for. A care recipient under retirement age may be entitled to claim Disability Living Allowance, and one over retirement age can claim Attendance Allowance. Carers who provide more than 35 hours care per week may be able to claim Carers’ Allowance.

⁵⁸ See Mary Daly, ‘Care as a Good for Social Policy’, *Journal of Social Policy* 31 2 251-270

billion every year⁵⁹, and by 2005 Carers UK claimed it was £57.4 billion per year - or the entire NHS budget all over again.⁶⁰ This level of economic burden simply could not be assumed by the state without such significant consequences for the taxation system as would be politically unacceptable, making the 10p tax rate debacle look petty in the extreme!

In effect, the family is subsidising society's responsibilities: the family provides the means which render 'care in the community' feasible. Superficial familiarity with the recent history of mental health care in England and Wales illustrates the point. The move to 'care in the community' for the mentally ill presupposed that informal networks of family care were both existing and willing. When it transpired that the supposition was wrong, the current crisis in institutional mental health care was precipitated.

Once it is accepted that families are integral to both individual and collective healthcare, the role ascribed to families in determining healthcare issues can be seen as a measure of society's understanding and appreciation of the contribution that families make. Appreciation can play a vital role in oiling the mechanisms of family care, because appreciation always makes effort and self-sacrifice more bearable and support of a patient in the family *does* demand effort and self-sacrifice on the part of the patient's family.

The impact on the family: People rarely *choose* to assume the burden of care for a sick or disabled person within the family. Fate deals her cards without consultation. Accidents happen; diseases develop; congenital defects go undetected. The family connection predates the medical condition and the responsibility is incurred in ignorance of the future.

⁵⁹ Institute of Actuaries for The Princess Royal Trust for Carers, quoted in 'Eight Hours a Day and Taken for Granted?' (n8 above) at p1. The report defines a carer as "anybody who is helping to look after a partner, relative or friend..." and focuses on those for whom caring is a full-time concern of more than 8 hours a day. The definition of family which I have offered includes all these people.

⁶⁰ Carers UK *Facts About Carers* (London: Carers UK 2005) p1, as quoted by Herring in 'Where are the carers in healthcare law and ethics?' at p53.

Where a medical condition is short-lived, an episode of acute care can be experienced simply as a period of exceptional demands but where the condition is chronic, the day-to-day requirements of dealing with illness or disability can take over the family's previous life, and even the most mundane freedoms can become swamped. As the caring spouse of an Alzheimer's patient put it: "I'm just a slave to her."⁶¹ The degree to which one family member's medical needs can take over a family is graphically illustrated by Nelson and Nelson⁶² in the description of Tony:

'Tony was 24 years old, suffered muscular dystrophy and had already outlived his life expectancy by six years. He was small and thin, but had an IQ of 142 and an excellent record as a graduate student. When his condition was first diagnosed, his parents were told that he would not live to adulthood and had made him the centre of family life, often sending his sisters away to stay with relatives so that they could cope. One of the sisters, Angela, married at 16 to escape this brother-centred family, but then nursed her parents through terminal illness. Her mother's last words to her were 'look after Tony'. Angela took Tony into her home, supporting him financially and emotionally. Tony is now coming to the end of a stint at rehabilitation hospital teaching him independence skills but he plans to return to Angela's home on discharge. Angela is feeling suicidal at the demands of her brother and two teenage children. The kids and her husband have had enough. The other sister, now 28 and married with three children, holds her parents' premature deaths and her sister's current state against Tony, and refuses to help. The Social Worker is worried about Tony's rights to self-determination. He is dying after all, and he ought not to die among strangers.'

⁶¹ In Brenda Gillies' 'Acting up: role ambiguity and the legal recognition of carers' [2000] *Ageing and Society* 20 429-444 at p436.

⁶² *The Patient In The Family: An Ethic of Medicine and Families* at p26-28, retelling a study from Janet Haas, Arthur Caplan & Daniel Callahan (eds.) *Case Studies in Ethics and Medical Rehabilitation* (The Hastings Center, Braircliff Manor NY 1988)

Family devotion can be strained to breaking point. Not surprisingly, family members can feel a great deal of resentment of their new role:

“We didn’t apply for the job. Most of us don’t have a vocation for it. We’ve had no training. We’re certain we aren’t much good at it. Plus, and this is the nub of the matter, we’ve got our own life to lead. Are we expected to throw that away because of somebody else’s disability? We’ve got things to do, places to go. And now it looks as if we might not be able to.

But aren’t we just as important as they are? Why are we expected to sacrifice ourselves for somebody else? And yes, I mean sacrifice. We’re not talking about giving up five minutes of time once or twice a week. Or putting off a holiday from this year to next. We’re talking about our entire way of life. The old one wasn’t perfect, but it was the best we could do. This new one isn’t even ours. It’s somebody else’s life. And it’s one that doesn’t suit us at all.”⁶³

It should come as no surprise then that research demonstrates a plethora of ill-effects that having a patient in the family has on the wider family. A wealth of studies shows that providing unpaid care for disabled and older people is associated with increased rates of anxiety, depression and psychiatric illness.⁶⁴ Families of patients receiving palliative care have been shown to suffer psychological effects⁶⁵ which can be quite profound. Physical health suffers too. Family carers have been found to suffer maladies ranging from increased rates of hypertension,⁶⁶ through lower immune response⁶⁷ and altered response to

⁶³ Hugh Marriott, ‘The Selfish Pig’s Guide to Caring’ at p9. For further discussion of this, see Herring’s ‘Where are the Carers in Healthcare Law and Ethics?’ (2007) *Legal Studies* 27 51-73.

⁶⁴ For example, Schulz R, O’Brien A, Bookwala J & Fleissner K (1995) ‘Psychiatric and physical morbidity effects of dementia caregiving: prevalence, correlates and causes.’ *The Gerontologist* 35, 771-791; Singleton N, Aye Maung N, Cowie A Sparks J Bumpstead R & Meltzer H (2002), *Mental Health of Carers*, London: The Stationery Office.

⁶⁵ Kristjanson LJ & Aoun S (2004) ‘Palliative care for families: remembering the hidden patients’ *Canadian Journal of Psychiatry* 49 359-365

⁶⁶ King AC, Oka RK & Young DR (1994) ‘Ambulatory blood pressure and heart rate responses to the stress of work and caregiving in older women’, *Journal of Gerontology* 49 239-245.

⁶⁷ Kiecolt-Glaser JK, Dura JR, Speicher CE et al (1991) ‘Spousal caregivers of dementia victims: longitudinal changes in immunity and health’, *Psychosomatic Medicine* 53 345-361

influenza vaccination,⁶⁸ to slowed response to wound healing.⁶⁹ A care burden of more than 9 hours a week is associated with twice the risk of coronary heart disease in female carers;⁷⁰ and the life expectancy of an elderly person living with someone for whom they care is shortened.⁷¹

These ill-effects are not isolated incidents of misfortune, but a broad social trend. The 2001 census indicated that about 6 million people in the UK considered themselves to have caring responsibilities for the sick and infirm.⁷² Michael Hurst recently analysed data from the British Household Panel Surveys between 1991 and 2000 – and thereby gained a broadly representative snapshot of the nation’s non-institutional population over a decade – and concluded that family caregiving⁷³ is an underlying social determinant in the creation of society’s health inequalities.

Nor is it simply health that suffers. Above all else, caring takes *time*. Those who need to spend their time caring for sick relatives cannot spend it in economically productive activities. They cannot earn a living. Over three-quarters of those with caring responsibilities suffer financially and many end up in poverty during retirement as a result of not having been able to work.⁷⁴ Such benefit provision as is available often goes unclaimed,⁷⁵ either lost to unwarranted complexity of claim forms, or else sacrificed to preserve whatever dignity remains to those denied the opportunity of economic productivity and yet conscious of a stigma attached to reliance on state ‘handouts’. And, as if to ice the cake, along with

⁶⁸ Kiecolt-Glaser JK, Glaser R, Gravenstein S et al (1996) ‘Chronic stress alters the immune response to influenza virus vaccine in older adults’, *Proceedings of the National Academy of Sciences of USA* 93 3043-3047

⁶⁹ Kiecolt-Glaser JK, Marucha PT, Malarkey WB et al (1995) ‘Slowing of wound healing by psychological stress’, *Lancet* 346 1194-1196

⁷⁰ Sunmin Lee SD, Golditz GA, Berkman LF et al (2003) ‘Care-giving and risk of coronary heart disease in US women; a prospective study’, *American Journal of Preventative Medicine* 24 113-119

⁷¹ Schulz R & Beach SR (1999) ‘Caregiving as a risk factor for mortality: the caregiver health effects study’ *Journal of American Medical Association* 282 2215-2219

⁷² Carers UK *Facts About Carers* (London: Carers UK 2005)

⁷³ His definition excluded paid carers and unpaid carers who help clients of voluntary organisations, whom he regards as “distinct from...family carers” (p698).

⁷⁴ Carers UK, *Carers UK Welcomes White Paper*, (London: Carers UK 2006)

⁷⁵ At the rate of nearly £750 million per year according to Carers UK: ‘Carers Missing £750m benefits’ BBC Newsonline 2nd December 2005.

weakened health and finances and restricted time, go social isolation and exclusion.

Since family care for its weakest members is often simply an exaggerated expression of 'normal' family functioning, the burden of caring falls disproportionately on the women in the family.⁷⁶ Where a carer's role is self-identified, the proportion of carers who are female ranges from 58⁷⁷ to 61%.⁷⁸ This figure, and the gender gap it implies, is only likely to increase when we remember that our definition of family, unlike the government's definition of carers, includes the parenting of able-bodied children.⁷⁹

Treatment Decisions: Implications of the impact *of* and *on* families

Evaluation of family involvement in patient care suggests that it brings benefit to both the patient and society, but at a cost to the family and to the women in the family in particular. Medical outcomes and family flourishing are mutually dependent. It seems a small step in logic to claim that this interdependence makes a just foundation for the family to play a role in the medical decision-making process. Modern society no longer accepts that services can be extracted from whole swathes of society without consent or recompense. It would be unnecessarily limiting to assume that family support will *not* be made available to medical advantage but wholly unjust to take it for granted. Individuals and society may only take the fruits of other's labours with consent, and respectfully⁸⁰ and therefore whenever the medical treatment of one of its

⁷⁶ See Bond J (1992) 'The politics of caregiving: the professionalisation of informal care.' *Ageing & Society* 12 5-21.

⁷⁷ 2001 Census

⁷⁸ Singleton N, Maung NA, Cowie J et al (2002) *Mental Health of Carers*, London: Office of National Statistics

⁷⁹ Although there may be a small disparity the other way if we were to focus exclusively on care of elderly patients. According to the 2001 census, 14% of men - as opposed to 12% of women - aged 65-84 were carers. Women's greater life expectancy and geriatric dementia may account for this. See Michael Fine & Caroline Glendinning, 'Dependence, independence or interdependence? Revisiting the concepts of "care" and "dependency".' [2005] *Ageing & Society* 25 601-621.

⁸⁰ The Recommendations of The Princess Royal Trust report (above n7), begin with these two:

members is in issue, the family should in fairness play a contributory part in the decision-making process. The impact on the family of the range of options under consideration should be a legitimate consideration.

The difficulty here is that the step of including the family as anything other than information providers in medical treatment decisions – however small in logic or social etiquette – would be taken *against* the flow of the prevailing view of patients as autonomous individuals. The dominant medical ethic insists on every patient’s right of self-determination. Recognising family interests as an element in the decision-making process would erode that principle, and ultimately run the risk of losing the individual to the collective. Abuse of family power is a real danger, from which individuals – particularly when made additionally vulnerable by illness or incapacity – need to be protected. In terms of current orthodoxy, therefore, the small step in logic is a step in the wrong direction.

So, it would appear that the medical decision-making process has to take sides in a conflict of principle: the patient’s autonomy in one corner, and fairness and justice to caring families in the other. The prospects of amicable resolution do not look good when the dilemma is expressed in such oppositional terms.

However, the assumption that excluding consideration of others is the best way to protect the individual is questionable. If familial motives and concerns are openly aired, they can be assessed for what they are, and weighed accordingly. If instead they are excluded from open consideration, they will not disappear, but will simply be driven underground, “apt to come out subtly, in the form of covert pressure, that won’t be acknowledged by anyone and so pose a far greater threat to the patient.”⁸¹

It may be countered that assuming a default position of mistrust of *all* families is safer than trying to assess individual families. Individual assessments are fallible,

(a) “Statutory authorities should not assume that a relative will automatically be able to put their life on hold in order to become a carer.”

(b) “Carers should be involved in decision-making about the future care of the person they are looking after.”

⁸¹ Nelson & Nelson, *A Patient In The Family* at p115.

but a general mistrust protects against abusive tendencies where such exists, and harms nobody where they do not. However, such an argument is delusional. A general assumption of mistrust *does* harm non-abusive families. It undermines faith and confidence in relationships, in a context and on occasions where they are most needed. As Nelson & Nelson put it, “systematically treating people as if they were adversaries is likely to make them so. At the very least, the default assumption of mistrust sets up emotional barriers among family members at the precise moment when they need all the comfort intimacy can give them.”⁸²

Moreover, if the fear is that admitting family considerations risks admitting family abuse, we must also acknowledge its mirror image: if the family is *not* allowed to contribute to the process or to have its interests considered, particularly when illness may make patients additionally selfish or self-absorbed, there is a risk of endorsing unreasonable demands on the family. Furthermore, since much of the practical caring aspect of family interdependence is undertaken by the women of the family, such an approach also risks entrenching gender inequality. Strictly autonomous decision-making comes at a cost to others and to society at large.

The considerations of autonomy, fairness and justice which appear to put families and individuals into opposition are abstract terms but medical decisions are taken in the real world. In reality, the patient’s interests and the family interests are not so oppositional, precisely because of the interdependence which has marked out the family for special consideration in the first place. Juggling different interests is what families are all about.⁸³

In reality, most families want what is best for their patient, which is why they are prepared to make the sacrifices involved in caring. Most patients do not want to be any more of a burden on their families than is unavoidable. Even where patients are not capable of such altruistic appreciation of their situation, it is

⁸² *A Patient In The Family*, p 115-116

⁸³ “It is the business of families to maintain a continued tension between the fusion of the one and individuation of the other. If the tension isn’t present, the family disintegrates: either it collapses under unrealistic demands for emotional fulfilment, or its members drift off to pursue their personal projects in splendid isolation.” : Nelson & Nelson, *A Patient In the Family* at p 34.

demonstrably not going to advance their cause to make treatment choices which leave their family support systems so embattled and exhausted as to render them useless. Moreover, family life has a fluid dynamic, and “one man in his time plays many parts.”⁸⁴ Individuals will move in and out of the patient role over their lifetime. The adult caring children were once cared for by their now ailing parent, and so the benefits and burdens are shared around with rough equity. That is the point of interdependence.

In the real world of court decisions, the quest must be to find a way to take that small logical step of admitting a role for families in the decision-making process, and the interests of families as part of the considerations, without endangering the personal liberties of either patient or family. In other words, to *balance* competing interests. It *matters* that the law finds and articulates that balance, because medical treatment decisions impact on the lives of so many people, and ultimately on the whole of society.

Conclusions

In twenty-first century Britain, the social meaning of ‘family’ is fluid and context-dependent. In considerations of medical treatment decisions, ‘family’ is understood more broadly than ties of genetics or terms of legal status can define, focussing instead on relationships of shared history, present connection, and ongoing interdependence.

The legal concept of ‘family’ rests on common understanding, and shifts with prevailing social conditions. To date, development of the judicial understanding of ‘family’ has followed a quasi-marital model, but statutory developments encompass wider possibilities, and the mechanism of judicial development allows the prospect of further reinterpretation, in line with social understanding in the medical context, when the opportunity arises.

⁸⁴ William Shakespeare, ‘As You Like It’, Act 2 sc. 7, 1.139.

It is important that the law recognises the full constituency of the ‘family’ when resolving medical treatment disputes because the people and the context have such mutual impact. A supportive family improves both the experience and the prognosis of the patient, and makes possible the health policies of successive, current and future governments. Conversely, fulfilling the supportive role makes heavy demands on families, which cry out for recognition and justify a family’s claim to be heard.

Admitting the family into the process and considerations of medical decision-making would challenge the prevailing orthodoxy of patient autonomy. A balance will need to be struck between the interests of individuals and the interests of a collective. Finding and articulating such a balance in law will have important implications for countless individuals and for wider society. The role which courts ascribe to families in cases of disputed medical treatment does nothing less than encapsulate a vision of the kind of society we want to be.

Chapter 2

Literature Review: An Ethical Framework

The purpose of this chapter is to review the different ethical frameworks which may be applied to the research question, using the device of fictional case studies.

Introduction

The relationship between law and ethics is a reciprocal one. An ethical framework is an essential practical guide to the determination of disputes, and a useful tool for the critical assessment of legal frameworks.¹ If we can identify an acceptable moral framework from which to consider the role of the family in the determination of disputed treatment issues, then we can claim authority to evaluate the approach taken by the courts.

There is a range of theories available for adoption. I shall consider in turn theoretical approaches which emphasise procedure, outcome, action, agent and relationship. I shall then explore the work of Beauchamp and Childress, which formulates the dominant medical ethic of our time in four practical principles, appropriating the strongest parts of each theoretical approach, but at the expense of philosophical unity. I shall test each approach through the prism of three fictional case studies, to assess their merits specifically in the context of the family's role in medical decision-making disputes.

¹ Such is the relationship between legal and moral values that many commentators would consider any attempt to disengage them as 'pointless', because 'when we talk about legal rules, we are inevitably drawn into a discussion of moral rules.' See for example A. Sommerville, quoting Mason, McColl Smith & Laurie, in 'Juggling Law, Ethics, and Intuition: Practical Answers to Awkward Questions' (2003) *Journal of Medical Ethics* 281 at p282.

The case studies

Case 1: Annie

Annie is 8 years old and lives at home with her parents and sister. She was born with severe mental retardation. She has no motor control, and requires physical manipulation of her limbs for exercise. She has no recognised form of communication, but she recognises family members and responds to loving relationships with smiles and gurgles. She enjoys music and tactile stimulations, and shows fear and anxiety with changes of environment.

Physically she is developing normally. Her family is concerned that she will soon be too large and heavy for them to carry around. If they cannot carry her, their ability to move her, to take her out of the house and involve her in everyday activities will be significantly reduced and her quality of life will diminish. They seek medical intervention to stop her growth and physical development.

Case 2: Bella

Bella is 15. She has shown significant weight loss in the last 4 months, since formulating an ambition to become a model. She draws inspiration from a website featuring information about modelling, agencies, salaries etc. She is insistent that she wants to reduce her body to a size 0, to secure lucrative contracts and the lifestyle to which she aspires.

Bella's parents are dismayed at her ambitions and deeply concerned about her health. They have taken her to doctors who have advised on the damage being done to Bella's body by her near-starvation diet. The medical recommendation is for a sustained period of enhanced nutrition, which Bella resists.

Case 3: Cecil

Cecil is 93 years old, and his physical health is degenerating with old age. He has the opportunity of a hip replacement operation, which has the prospect of improving his mobility. He is cantankerous and imperious in making demands on his septuagenarian daughters, who provide the practical support which enables him to live independently at the moment.

An ethical framework

The study of ethics, or moral philosophy, is an investigation of the underlying reasons or justifications for specific beliefs or codes of practice, with an implicit search for what is the best, the most *right*, way of doing things. Medical decisions are taken in times of stress, and often at considerable speed. The process and the conclusions are likely to affect more lives than the patient's alone, and all parties have interests and fears of their own. An ethical framework is an essential practical guide if dialogue between the parties is to be achieved in the dispassionate, impartial way most likely to optimise outcome.²

Whilst this is not a piece of research in philosophy, considerations of ethics are fundamental to a critical examination of the law. Many legal principles purport to be based upon, and in some sense derive their authority from, ethical foundations - like the legal requirement of consent to medical treatment, which has its roots in the ethical emphasis on autonomy. Where, as in medical decision making, the issues which fall to be determined are concerned with both rapidly advancing science and the infinite variety of people, it is inevitable that black letter law alone will often be insufficiently developed to provide practical guidance, and a deeper wealth of legitimacy will need to be plundered. Just as importantly, there may be ethical reasons for limiting how far the law is allowed to extend, as is demonstrated in the battles about regulation of the conduct of pregnant women.

² I suggest that an outcome is optimised if the decision reached meets the needs of all the people involved in the process and/or affected by its outcome, and if the process of reaching it is experienced by all of them as fair. Therefore an optimal outcome will only be achieved if the decision-making process is unprejudiced, and gives all participants the potential to express their views fairly and openly.

Furthermore, the critical discipline of ethics provides a useful tool for attempting to answer the big, open questions which preface individual cases. Moral philosophy demands clarity in the use of key terms; it requires consistency in practical application; and it clamours for coherence. A defensible moral approach to the individual medical decision must conform to other beliefs which are generally held to be true for different medical decisions; which in turn leads to the formulation of systematic explanation of how the general approach to issues of medical decision making can be resolved.

The study of ethics does not, however, provide a simple answer. Philosophers can disagree at least as much as lay people over which theories are most appropriate in any given situation. There is a range of competing theories, each with its own shades of opinion, and a fully inclusive survey would be a lifetime's work. For our purposes, the general approaches which offer the most potential for enlightenment may be categorised according to the locus of their central emphasis. Casuists emphasise the **procedure** for determining right and wrong. Consequentialist theories, of which the most significant brand is utilitarianism, judge the rightfulness of actions in terms of their overall **outcome**. Deontological theories, which began with Kant and include rights-based systems, decree **actions** to be intrinsically right or wrong, whatever the consequences. According to virtue ethics, the morality of the decision is determined by the character of the **agent** making it. The ethics of care focus on the imperative of maintaining connection in a web of compassionate **relationships**. Principlism tries to take the best bits of all these approaches, and offers an approach tailor-made to medical ethics, based on four **principles** said to encapsulate common morality.

On any given issue adherents to different theories may reach radically different conclusions; or they may reach the same conclusions, on differing grounds. It may seem therefore that consideration of the range of philosophical approaches would yield little to guide the courts in medical decision making. However, a critical assessment of the concepts underlying the theories can help demonstrate their strengths and weaknesses in a given area. Seeking consistency in judgments across different issues can force us to admit when a judgment is one of

instinctive reaction, rather than general moral belief; and the demand for justification engenders understanding. As we appreciate the reasons behind conclusions which differ from our own, we may even shift our point of view.³

Since we are looking for a theoretical framework which can be applied by judges to determine medical issues on which patients, families and doctors take different views, it is reasonable to begin with a consideration of the ethical approach which is closest in methodology to traditional legal reasoning.

Procedure based theory

Casuistry is a method of reaching moral conclusions by examining how similar issues have been determined in the past and proceeding by way of analogy, much in the same way as the common lawyer looks to case precedents. It originated in medieval thinking, but modern proponents, like Jonsen and Toulmin,⁴ contend that its methodology is particularly adept at offering guidance in ethical issues of rapid, and sometimes unpredictable, scientific progress. It works from the bottom, up; from cases to principles, and not vice versa. A deep knowledge of relevant historical situations, how they occurred and were resolved, with what implications, enables the casuist to construct a spectrum of paradigmatically right and wrong actions, into which the current problem is positioned by way of direct comparison. Overarching principle may emerge, but it is not necessary or even particularly desirable. The common philosophical aim of a single unified theory is simply inappropriate. Instead casuistry prides itself on its practicality, its ability to offer concrete advice in real situations.⁵

³ Broadly, these are the justifications which Beauchamp and Childress offer for their selection of four principles as the basis for a bioethical approach.

⁴ See for example Albert Jonsen '*Casuistry and Clinical Ethics*' (1986) *Theoretical Medicine* 65, and '*Casuistry as Methodology in Clinical Ethics*' (1991) *Theoretical Medicine* 295; Jonsen A & Toulmin S *The Abuse of Casuistry* (1988); and Toulmin S. 'The Tyranny of Principles' (*Hastings Center Report* 11, 31-39).

⁵ See John Arras 'Getting Down to Cases: The Revival of Casuistry in Bioethics' (1991) *Journal of Medicine & Philosophy* 29

This approach has its attractions. It is a methodology readily understood by lawyers, and it is not fixed to the mores of any particular epoch. By its very process, the spectrum of known examples is amplified over time as and when each novel situation occurs, each one taking its place *because* of its new features. In this way ethical reasoning is able to keep pace exactly with the developments in medical science.

However, the approach also has its limits. As Arras, and Beauchamp and Childress, point out,⁶ for the casuist to move constructively from case to case, there must be some recognised rule of moral relevance connecting them. There has to be something which makes the bridge between two cases. The creation or discovery of linking moral norms cannot be achieved by analogy itself.

Casuists stress that scenarios resonate beyond themselves and evolve into generalisations which form the connecting links. If that is so, then the validity of the links depends on cases having been interpreted correctly in the first place. It is possible for generalisations to evolve in the wrong direction if they were improperly resolved from the outset. There is nothing intrinsic to the approach which safeguards against a biased development of cases, or a neglect of relevant features. As a result “casuistry lacks critical distance from cultural blindness, rash analogy, and mere popular opinion. ... In the end, casuistry is a method without content.”⁷

On this view, casuistry has little to offer a system of judicial dispute resolution. The best of the methodology we have already in the common law system of precedents, but with the added corrective of a system of appeals. An ethical content is what we are lacking, and for that we must look elsewhere.

The deficiencies of casuistry are illustrated by a consideration of our case studies. The medical possibilities available to Annie are innovative and untested;

⁶ Arras ‘Getting Down to Cases: The Revival of Casuistry in Bioethics’ (1991) *Journal of Medicine & Philosophy* 29; T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* 394

⁷ T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* 394

and her care needs are as individual as her fingerprints. There can be no direct analogy from earlier cases. Finding a moral link via indirect analogy, such as non-therapeutic sterilisation, suggests an inadequate grasp of the true complexity of the situation.

In contrast, there have been numerous cases concerning anorexics and forcefeeding, which may offer analogies to Bella's situation. However, as we learn more about the mental aspect of food disorders, it may become apparent that what has been an acceptable approach in the past is in fact wrong. Proceeding by analogy may simply perpetuate poor treatment.

Cecil's reluctance to undergo hip replacement would go unquestioned, as the weight of authority emphasises his individual physical integrity, and the necessity for his consent to medical intervention. The true effect of *not* undergoing surgery, and all that implies both in terms of his own deteriorating mobility and therefore 'independence', and the increased burden on his elderly daughters, does not even enter into consideration.

Casuistry seems to offer little insight into any of our fictional scenarios. The best of its methodology may be shared anyway in the legal processes which determine medical treatment disputes; for moral guidance, we need to look elsewhere.

Outcome based theory

Consequentialist theories hold that actions are good or bad according to the balance of their end results. In any particular circumstances, the right action is that which produces the best overall outcome, when judged from an impersonal perspective giving equal weight to the interests of all affected parties.

The most significant consequentialist theory is utilitarianism, which is rooted in the thinking of Jeremy Bentham and John Stuart Mill,⁸ and advances a single principle of ethics, namely utility. According to this principle, we should always produce the maximal balance of positive value over disvalue (“the greatest good for the greatest number”), or if only undesirable results are possible, then the least possible disvalue.

Within consequentialist approaches, there is disagreement and debate about which values are to be maximised. Earlier theorists elevate intrinsic, agent-neutral goods, which are valuable in and for themselves, such as happiness, freedom or health. More recent theorists have a wider concept of intrinsic good, including agent-relative values such as friendship or personal autonomy. Whichever good is advanced, these theorists have in common the intention of producing the most of it possible, wherever it falls. *Preference utilitarians* differ in that for them, utility refers not to intrinsic goods, but to personal preferences. They aim to maximise the overall satisfaction of the personal preferences of the greatest number of individuals.

Whilst the emphasis on intrinsic “goods” gives the impression of aiming for positive beneficial ends, the choice of intrinsic good, at least for more recent utilitarians, is inherently subjective. Equally, even if we could all agree on the value to be maximised, the means of achieving it may be questionable: some people experience pleasure only at the pain of others. As Rosalind Hursthouse points out, “there is no room in utilitarianism, with its ‘realistic’ eschewal of ideals, for the idea that some sorts of pleasure or enjoyment are wrong in themselves.”⁹

The emphasis on net aggregate satisfaction can also lead to problems of unjust distribution. The theory has no mechanism for disavowal of unequal social contribution, and can therefore lead to conclusions which offend the common

⁸ See Jeremy Bentham’s *An Introduction to the Principles of Morals and Legislation*; and JS Mill’s *Utilitarianism* and *A System of Logic*.

⁹ Rosalind Hursthouse, *Beginning Lives* (Oxford: Basil Blackwell, 1987), 154.

understanding of social justice, like Weinstein and Stason's hypertension study.¹⁰ Their research demonstrated the unsurprising fact that people lacking healthcare insurance were less likely than those *with* such benefits to follow the long-term treatment regime which would improve their health, leading them to conclude that overall welfare would be maximized by targeting additional resources at those already provided for, at the expense of the poorest, and most needy, section of the community.

The interests of the majority can override the rights of the minority all the more easily if we are concerned not with intrinsic goods but personal preferences, as Rosalind Hursthouse illustrates in the context of euthanasia: the preference of the victim for continued life could be outweighed by the combined preferences of his family that the old man should die so that they can have his money.¹¹ Such an outcome would be contrary to conventional morality, but if we seek to exclude it by formulating a range of acceptable preferences or means of achieving intrinsic goods, we act inconsistently with the principle of utility¹² where the ends justify the means.

Controversy also arises over whether the principle of utility pertains to individual acts in particular circumstances, or instead to rules of general application. *Act utilitarians*, such as Peter Singer,¹³ look directly to the principle of utility to determine the right action in any given situation; rules may be useful action

¹⁰ Two medical researchers wanted to find the most cost-effective way of controlling hypertension in the American population. They found that one of the most important antecedent conditions for serious hypertension-related medical problems was non-adherence to treatment programmes. Non-adherence is much higher in patients who are screened and treated in the emergency room, than for those treated by primary care doctors. Therefore it was most cost-effective to target patients already being treated in primary care, than to identify new cases among those without regular medical care. It is disproportionately lower income people who do not have primary medical care. Therefore the researcher's conclusion had the effect of excluding the poorest sector of society, with the most pressing need for medical attention, from the benefits of high blood pressure education and management. The researchers were not comfortable about this, and expressly referred to utilitarian principles for legitimacy. (Milton Weinstein and William B Stason, *Hypertension* (Cambridge, MA: Harvard University Press, 1977); 'Public Health Rounds at the Harvard School of Public Health: Allocating of Resources to Manage Hypertension', (1977) *New England Journal of Medicine* 296, 732-39; 'Allocation Resources: The Case of Hypertension', *Hastings Center Report* 7 (October 1977) 24-29.

¹¹ *Beginning Lives* at p146

¹² See Madison Powers, 'Repugnant Desires and the Two-Tier Conception of Utility', (1994) *Utilitas* 6 171-176.

¹³ *Practical Ethics* (Cambridge; Cambridge University Press, 1993)

guides, but they are expendable in any instance where they do not promote utility. The making of exceptions, it is argued, is consistent with ordinary moral belief; and when the breaking of rules itself offends our moral convictions, it is those convictions which need to be revised, not the principle of utility.

In contrast *rule utilitarians*, such as R.M. Hare,¹⁴ abide by certain rules, which are justified as advancing utility in the generality of life, even though following them in a particular isolated situation would fail to maximise utility. This reasoning was used by Worthington Hooker, a prominent figure in nineteenth century medicine and medical ethics,¹⁵ in defence of the prohibition against deception in medicine. He conceded that deception can sometimes best advance an individual patient's health, but argued that widespread deception would have an increasingly negative effect over time and would eventually produce more harm than good, undermining the trust which could be placed in physicians. The general benefit to society of observance of the rule against deception outweighs the benefit of deception in the individual case; abandonment of the rule for the individual threatens the integrity of the particular rule and the whole system.

Hooker's absolute insistence on rules may be criticised as unfaithful to the principle of utility. Seeking to keep the faith, JJC Smart¹⁶ proposes a middle way of *selective* obedience to rules. He denies that either moral rules or general morality are eroded by individual breaches as long as, in the particular circumstances, breach of the rule is better for all concerned than observance, and general conformity to moral rules is not undermined. Hooker would doubtless berate the convenient relativism of this view, but it offers a realistic applicability which retains consistency with the principle of utility, whether a rule is to be breached or observed.

¹⁴ See for example, 'Methods of Bioethics: some defective proposals' (1994) *Monash Bioethics Review* 34-47

¹⁵ Cited by Beaucamp and Childress in *Principles of Biomedical Ethics* at p344.

¹⁶ *An Outline of a System of Utilitarian Ethics*, (Melbourne: University Press, 1961), and 'Extreme and Restricted Utilitarianism' in Michael Bayles (ed) *Contemporary Utilitarianism*, (Garden City, NY: Doubleday & Co, 1968).

Even for rule utilitarians, the principle of utility is exclusively absolute. Any derivative rules are of a lesser status, and may be revised as social conditions require. This gives the theory constructive adaptability, but also leaves it vulnerable to the criticism of failing to prevent immoral actions. Without any fixed concept of “acceptability”, it is conceivable to utilitarians that social circumstances may exist where immoral acts (as judged by common standards) may be not just permitted but obligatory. Consider the possibility of ending a devastating war by torturing children to reveal the whereabouts of their soldier fathers.¹⁷ Utilitarianism requires torture, without offering any compensatory and particularised justification for surrendering restraints. It is forced to do so because, as Rosalind Hursthouse¹⁸ points out, it grossly underestimates the range of considerations which are relevant to the morality of an action.

In its requirement always of the *highest* value, utilitarianism is a very demanding ethic, so far removed from our common expectations that it has been called “ethics of fantasy.”¹⁹ It requires people to set aside personal goals and ambitions, in order to maximise outcomes for others, and has the surprising effect of making it impossible to recognise any act as going “beyond the call of duty”, because there is no room for distinction between obligatory actions and supererogatory actions.²⁰ This is clearly alien to common experience. We hail living donors of body parts for transplantation as heroes; we do not *expect* that a kidney should be donated, even to save a life. Utilitarianism entails just such an expectation, and in doing so it expects too much.

Yet if there are weaknesses in consequentialist theories, there are strengths too. At least on a superficial level, utilitarianism is easy to grasp and easy to recite as a working guide in real life, which makes it attractive and practicable. Utilitarians can and do claim that their theory simply makes explicit and systematic what is already happening in everyday deliberations all the time. Looking to the results of one’s actions seems to encourage social responsibility,

¹⁷ As do Beauchamp & Childress in *Principles of Biomedical Ethics* at p346

¹⁸ *Beginning Lives* at p178

¹⁹ John Mackie, *Ethics: Inventing Right and Wrong* (New York: Penguin Books, 1977) 129

²⁰ See Alan Donagan, ‘Is there a credible form of utilitarianism?’, n8 above 187-202

which is to be welcomed;²¹ and seeing morality in terms of promoting general welfare is a beneficent and optimistic approach. The emphasis on overall social welfare may be a refreshing and useful counterweight to the claims of traditional conviction.²² Taking into account all interests, and judging impartially, make a sound and generally acceptable basis for the formulation of public policy. The impetus of the theory is egalitarian, because everyone's welfare is equally important.

If a utilitarian approach is taken to our case studies, the enormity of the surgical intervention fades in comparison to the preservation of quality of life for Annie, our profoundly handicapped eight year old. The normal privileges of physical development to adulthood would be for Annie only more intimate physical dependency, and the risk of abusive relationships. Further restricted in mobility, her opportunities for those experiences which currently give her the limited pleasure she is capable of experiencing would be reduced. Her parents would see their ability to lead a normal life still further curtailed, or have to accept that living a normal life could only be achieved by surrendering the care of their daughter to others, with all the guilt that would entail. For *act utilitarians*, the balance of good seems tilted in favour of intervention.

However it may be that, for *rule utilitarians*, the calculation would work differently. If we have a rule that, in order to promote and safeguard open democratic society, we do not allow non-therapeutic medical intervention on individuals with mental disability – as indeed we may, after the eugenic experiments of the early twentieth century, and its ultimate realisation in the holocaust of World War II – then the rule directs us *against* the proposed treatment for Annie. *Rule utilitarians* would therefore deny Annie the maintenance of her quality of life, because a general prohibition against non-therapeutic surgery on mental defectives is better for society as a whole.

²¹ "Consequentialist reasoning may be fruitfully used even when consequentialism as such is not accepted. To ignore consequences is to leave an ethical story half told." Amartya Sen, *On Ethics and Economics*, (Oxford: Basil Blackwell, 1987) p75.

²² We have discussed above the dangers of tyrannous majorities, but what we first viewed as a weakness may also be a strength. For example, if almost everyone's interests can be promoted by overriding some property or autonomy rights, it may not be wrong to pursue social utility.

However, such a rule may simply beg the question of what is meant by therapy. The sustained quality of life which growth retardation apparently offers Annie may satisfy the utilitarian understanding of therapeutic benefit. If instead the rule is rephrased to one forbidding eugenics, a similar difficulty manifests itself. Eugenic medicine aims to control breeding, but the medical motivation behind the treatment proposed for Annie is maintenance of her quality of life; the sterilising effect of the treatment is merely incidental. Formulating a workable rule is apparently very difficult.

Even if an acceptable rule can be formulated, it offers uncertain protection of a general good when in opposition to an individual good. *Selective* rule utilitarians would almost certainly find the quality of life argument, the understanding of therapy and the motivation for treatment sufficient to simply disapply the rule in Annie's case. Even strict rule utilitarians may falter, since any rule is always subject to the absolute principle of utility. There are more lives than Annie's whose quality may be affected by this medical decision, and all of them suggest that *allowing* the surgery would maximise utility. A moral stance for the wider good of the community becomes impossible to sustain.

Recall that Bella has expressed a preference to eat only minimally: the size of her body is of greater importance to her than its health. It is a dubious preference from many angles, but Bella's refusal to eat 'properly' is rationally decided, and part of a self-selected life-plan; acceptability is not part of the consideration. However Bella is still a minor, and she has two parents and a team of medics, no doubt all of whom would prefer that she is adequately fed. The combined weight of their preferences would overrule Bella's, and a compulsory feeding programme would begin.

Force-feeding is physically invasive, and psychologically damaging. It may improve Bella's physical health, but at what cost to her mental well being? And if she resists the procedure, what is the cost to our moral sense of ourselves if we physically force it on her? Yet, if we disregard preferences and look simply to the balance of positive outcomes, any psychological and potential career

detriment to Bella has to be weighed against the physical gain to her, potentially saving her very existence. In sum total, the damage caused by compulsory feeding will struggle to tip the scales against the benefits, at least in an objective consideration of the balancing exercise, whatever Bella herself might feel. Strict utility too demands that we treat Bella against her will. An attempt to overcome any discomfort we may have with non-consensual treatment by making a rule against it is unlikely to succeed because, as Annie's case has already shown us, even if rules are not selectively disapplied, they are always subject to the ultimate principle of utility.

On the other hand, Cecil's daughters are afforded some comfort from the utilitarian approach. Cecil's physical abilities and therefore his independence will be improved by hip replacement, and the burden he represents to his daughters thereby eased. Cecil's *preference* to keep his old hip may be reasonable (a calculation of his prospects of surviving surgery, or a sincere commitment to homeopathic treatment only) or selfish (he may rather have his daughters at his beck and call, than the responsibilities of independence), but either way it will be outweighed by the preferences of his *two* daughters for a lighter burden of care.

Both strict and preference utility would require Cecil to put aside his reluctance to undergo surgery. This may be a comfort to his daughters, but it is a high demand on Cecil. It may be wondered whether the daughters would welcome this moral approach quite so eagerly if the risks of the proposed treatment were viewed differently. If the surgery carried a high risk to Cecil (he is 93 after all!), so that the balance of likely benefit was *against* it, utilitarianism would expect the daughters to set aside their own hopes of reduced burdens and gentle retirement, and to soldier on for the sake of their father.

Annie, Bella and Cecil show us that outcome-based theories lead us to individual treatment decisions which carry a significant cost to our wider moral vision of ourselves. If we accept that limiting Annie's growth offers her and her family the best quality of life, we admit qualification to our moral taboo against medical social engineering. If we accept that the balance of good is in favour of Bella's survival, we must also accept that patients may be treated against their will. And

if we accept that the needs of Cecil's daughters weigh in the balance of good and bad outcomes, we acknowledge that patients owe obligations to people other than themselves, even to the point of submitting to invasive surgery. Securing the optimal outcome in individual cases cannot be achieved without compromise of our broader moral assumptions.

Action based theory

Action based theories are founded in the thought of Immanuel Kant (1724 – 1804).²³ His work is complex, but its distinctive contribution is an emphasis on morality grounded in reason. He viewed human beings as creatures with unique powers of rationality, and therefore the ability to act according to reason rather than desire. For Kant, the moral worth of an act depends exclusively on the moral acceptability of the rule of obligation which engenders it. This type of approach may be called 'deontic.'²⁴

The moral value of an act is not, however, determined simply by its compliance with a moral obligation. There has to be a rational element to it. The act must also be motivated by the moral obligation: the agent must intend what she knows to be morally required. This is what Kant means when he refers to moral autonomy. Compliance with obligation by accident, or through fear, ambition, or some other extraneous motivation, is not sufficient to give the act moral validity; in fact, it is morally indistinguishable from acting under coercion of others. Kant calls this "heteronomy", and it is very much a lesser state. For Kant, moral autonomy is the mark of human dignity.

To be morally acceptable, the rule of obligation – sometimes called the *maxim* – must pass a test, or tests, which Kant calls the *categorical imperative*. The test itself adds nothing to the content of the particular maxim under consideration. Instead it functions as a benchmark, against which the validity of the rule can be

²³ In particular, *The Critique of Pure Reason* (1781), *Groundwork for the Metaphysics of Morals* (1785), *Critique of Practical Reason* (1788), and *Metaphysics of Morals* (1797).

²⁴ From the Greek *deont-*, stem of *dei* 'it is right'. As used by D. Statman in *Virtue and Ethics: A Critical Reader*.

measured. It seems that the categorical imperative is not singular, because his two major formulations of it are very differently worded, and equally influential.

In its first formulation, Kant states the categorical imperative as follows: “I ought never to act except in such a way that I can also will that my maxim become a universal law.” This requires that rules of conduct are generalisable – that I would be as happy for everyone else to use it as a guide of their conduct, as I am to follow it in my actions. It also tests their “consistency”: a maxim must be capable of being conceived and willed without contradiction. Imagine a medical student desperate to pass his exams and qualify, even though he has not learned his material. He will cheat to ensure that his answers achieve the required passmark. Kant directs us to examine his maxim: “When I want to demonstrate knowledge, I will cheat”. This maxim will not pass the categorical imperative: exams only operate as evidence of knowledge if the person looking for the qualification expects that they were sat honestly. In a world where everyone cheated at exams, the passing of them would not demonstrate knowledge and their certificates would be useless.

The second formulation of the categorical imperative is that “one must act to treat every person as an end and never as a means only”. If an action is to be morally right, it must accord any and every human being with respect and dignity. This is an egalitarian requirement. It prohibits the privileging of any special group, such as those for whom the agent has a particular affinity or responsibility; and it precludes exempting any particular group, even in the interests of wider advantage. However it is not an absolute embargo. It is a bar to treating others *only* as a means to our own ends. As long as due respect and dignity is afforded, the coincidental assistance to our ends does not breach the categorical imperative. So as long as medical research subjects are properly informed and give valid consent, the advancement of the researcher’s ends which their bodies provide does not breach Kantian ethics.

From the second formulation of the categorical imperative, later philosophers such as Robert Nozick,²⁵ Bernard Williams²⁶ and Thomas Nagel²⁷ have developed a doctrine of “deontological constraints”, which maintains that certain actions are impermissible regardless of the consequences.

One expression of deontological constraint²⁸ is the ethical concept of ‘rights’. The language of rights is much more familiar to us than pure Kantian theory, because ‘rights’ are both a feature of and particularly congenial to the liberal individualism pervasive in our society. However that very familiarity makes it necessary to distinguish here the legal ‘rights’ with which we are familiar, and the older ethical concept of ‘natural’ rights with which we are presently concerned.

There can be no doubt that legal rights exist. Those which most clamour for public attention in current legal debate are the ones set out in the European Convention on Human Rights and incorporated into domestic law by the Human Rights Act 1998, but there are others, such as the ‘right’ to be treated under the NHS without direct payment. The common characteristic of *legal* rights is that they can be created and removed by decisions made by the appropriate body, such as parliament. Many philosophers, such as Jeremy Bentham,²⁹ would say that these are the *only* kind of rights; that it is nonsense to talk of anything deeper. In fact there was no attempt to consider any other kind of right until at least the late Middle Ages; the ancient Greek philosophers simply had no linguistic expression for a deeper kind of right.³⁰

²⁵ *Philosophical Explanations* (Boston, Harvard University Press 1981); *The Nature of Rationality* (Princeton University Press 1993); *Anarchy, State & Utopia* (New York, 1974); *The Examined Life: Philosophical Meditations* (Simon & Schuster 1990); *Coercion* (1969).

²⁶ *Ethics and the Limits of Philosophy* (1985); *Problems of the Self* (Cambridge, Cambridge University Press 1973)

²⁷ *The View From Nowhere* (New York, OUP 1986); *Mortal Questions* (Cambridge, CUP 1991)

²⁸ Although ‘rights’ may also be a rallying cry of rule utilitarians, because the *rule* imports obligation. However since, for rule utilitarians, rights are justified only because of their contribution to utility (which is how John Stuart Mill defended autonomy and liberty), they are only secondary to their approach.

²⁹ ‘Anarchical Fallacies’, reprinted in Melden AI (ed) *Human Rights*.

³⁰ See MP Golding’s ‘The Concept of Rights – An Historical Sketch’ in Brandman EL and Brandman B *Bioethics and Human Rights*.

However, there is also a “powerful and widespread moral intuition”³¹ that people simply do have certain basic and inalienable *moral* rights – in other words, a claim that individuals or groups can make on others or society, which is justified not by man-made law, but by *moral* principle. John Locke defended rights to “life, liberty and estate” as being God-given moral rights.³² Various national and international constitutions, including the French and the American Constitutions, claim moral rights; and a surprising rainbow of moral positions incorporate them, including

“the pro-life campaigner, who believes in the right to life of fetuses or severely defective neonates, or both; the person who is against apartheid, believing that South African apartheid laws violate[d] the equal moral rights to liberty of blacks; the libertarian capitalist, who believes that taxation violates the right to ‘keep the fruit of one’s own labour’; and the Marxist, who believes that capitalism infringes the right not to be exploited by others.”³³

The ability of so wide of spectrum of moral positions to adopt the discourse of rights demonstrates that the precise content of moral rights is of course open to debate. They are, however, broadly divisible into two categories: the universal and the special.

Universal moral rights are attributable to all people. HLA Hart considered that all the possible manifestations of universal moral rights boiled down to one fundamental right, namely “the equal right of all men to be free.”³⁴ He meant by this, freedom to exercise individual autonomy so far as is consistent with everyone’s else’s freedom to do the same thing. It is important to note that Hart’s fundamental right itself generates an equally fundamental obligation to respect

³¹ R. Gillon, ‘Rights’ (1985) *British Medical Journal* 290 1890 at p1890.

³² ‘Of Civil Government, Two Treatises’ reprinted in Carpenter WS (ed.) *Of Civil Government by John Locke Vol II*.

³³ R Gillon, ‘Rights’ (1985) *British Medical Journal* 290 1890 at 1890.

³⁴ ‘Are There Any Natural Rights?’ reprinted in Melden AI (ed.) *Human Rights*.

the autonomy of others, and therefore to accept restrictions on our own. As Gillon³⁵ points out, this is a Kantian position.

‘Special’ moral rights are possessed by some people, but not by others. They may arise from social relationships, such as parent and child, or from prior actions, such as a promise. The beneficiary of the promise has a special moral right to receive from the promisor the benefit of the promise: if X has promised to pay Y £10, Y can claim the money from him. Fortunately for X, not everybody will be able to claim him, but the right is nonetheless morally universalisable in that everyone to whom he makes the promise may claim.

Whenever Y has a right to claim *a* against X, it may be said that X has an obligation to do *a*. The relationship between rights and obligations is therefore correlative³⁶. It is not however parallel: the right imposes obligation on someone else, but not on the right holder,³⁷ on X not Y. The extent of the obligation is a matter of debate. Generally, as in Locke’s conception of moral right, constraints operate to impose an obligation to *refrain* from action. It does not necessarily follow that they impose any obligation to act positively. So, Y’s right to life imposes on X a moral obligation not to kill him, but will not generally impose on X an obligation positively to keep him alive.

Deontological constraints are therefore essentially negative duties – they specify what we cannot justifiably do to others, even in the pursuit of worthy goals. We may not perform non-therapeutic medical interventions on people without their consent, even if it does hold out the possibility of averting global catastrophe. They do not, however, specify any positive actions that should be taken for the sake of others. Therefore, they operate as guarantors of *minimum* standards. They

³⁵ R Gillon, ‘Rights’ (1985) British Medical Journal 290 1890 at 1891.

³⁶ Although, not every obligation carries a correlative right. Charity, for example, does not. John Stuart Mill distinguished duties of *perfect* and *imperfect* obligation. Duties of perfect obligation are those in virtue of which a correlative right resides in some person, and duties of imperfect obligation are those which do not give rise to any correlative right. For present purposes it is not necessary to take a stand on whether obligation precedes right, or vice versa.

³⁷ Although there may be an obligation on himself which corresponds to the right. JS Mill would say that the right not to be enslaved co-existed with a duty not to sell oneself into slavery: ‘On Liberty’ in Warnock M (ed) *Utilitarianism*.

set out not necessarily what we might aspire to, but what we may legitimately expect.

The operation of deontological constraints demonstrates a key difference between utilitarianism and action-based theory. Whereas the former demands an impartial view, weighing each person's interests equally to reach the maximal outcome, the latter affords moral weight to the agent's role, and is agent-relative. The perspective and sense of integrity of the agent are important in moral deliberations. It is part of the moral autonomy, and central to the emphasis on rationality.

There are problems with a Kantian approach, not least in the absolute view of obligation. Moral rules are categorical; they must be complied with. When two obligations conflict, there is no strategy by which the dilemma can be resolved. Each obligation remains good, and we are simply expected to do the impossible. Suppose I have promised to do X on Monday, and now discover that my project at work has overrun and needs to be completed. The obligation of promise-keeping is in conflict with an obligation of responsibility, yet I cannot do both things at once. Even more starkly, maybe I have promised to do X on Monday and Y when necessary; and Y becomes necessary on Monday, although I could not have foreseen that it would. The same obligation pulls me in two different directions. The Kantian approach offers me no way out. Absolute obligations are very difficult to accommodate with real life.

In its emphasis on rationality and obligations it is a very cold ethic. There is no space for emotion, caring and vulnerability. By privileging the rational autonomous independent actor, Kantian theory speaks to a very narrow section of society. Its vision of humanity is one which few of us recognise on a day to day basis, as we juggle our obligations to partners, dependants and friends. Periods of dependency and incapacity characterise human existence at least as much as periods of rational autonomy; and the state of illness or disability in which treatment disputes generally arise is an archetypal instance of this. A Kantian approach sits more comfortably with contractual arrangements between strangers

than it does with everyday decisions of family life, and particularly decisions of medical intervention.

On a Kantian view of the issues, the doctors treating Annie find themselves in a difficult position. Annie has never been an autonomous agent. Her family are asking the doctors to perform major surgical interventions when there is no physiological need. Annie is unable to have or express any views herself, but her interests require that she is able to continue in the care of her family, with as high a quality of life as can be achieved for her, and surgery would seem to help that. Nonetheless, the doctors may feel that their role as a physician, and their own moral integrity, prevents them from performing drastic and invasive surgery in the absence of physiological need.

Those that care for Bella are in no better a position. They must accord their patients dignity and respect. There is no dignity in forcefeeding, and the very idea of it is disrespectful of Bella's wishes, which may well be fully autonomous. Her right to life does not carry any correlative duty of positive action to preserve it. The urge to provide nutrition may be motivated by care, compassion and a wish to protect her from herself, but these are heteronomous compulsions, lacking moral worth. Force-feeding Bella would fail both formulations of the categorical imperative.

The reality that Cecil's long-term care depends on his daughters' continued ability to cope cannot inform the considerations of surgery. Allowing for an obligation of care, the maxim which allowed recognition of the demands of caring would be "when I need to care for someone, they must be treated according to my needs". It would fail the categorical imperative for lack of consistency. If Cecil is reluctant to undergo the hip transplant operation, all the doctors and daughters can do is try to persuade him to change his mind. There is a deontological constraint against medical treatment without consent, and no corresponding positive direction.

Annie, Bella and Cecil reveal the cold intellectualism of a deontic approach to medical treatment disputes. We may or may not like the outcomes, but we feel

the absence of any ‘bedside manner’ in the process of working out the dilemma. When there is no place for considering the practical effect of our refusal to intervene, no concession for misguided youth, and no recognition of the burdens we expect others to bear, our very humanity feels disregarded. When moral obligation requires us to overlook infinite individuality, it seems particularly ill-fitted to determine the kind of disputes with which we are concerned.

Agent based theory

Recently there has developed a resurgent interest in an old philosophy – that of the virtues. Proponents of virtue ethics emphasise the character of the actor; and “goodness” comes before rightness. An action is right if and only if it is what an agent with a virtuous character would do in the circumstances. Such philosophical approaches may be called ‘areteic.’³⁸

There are different varieties of virtue ethics, but Justin Oakley³⁹ has identified six positive features which unite them in distinction to other ethical approaches. The first of these is insistence on the primacy of character;⁴⁰ and the second, the pre-eminence of goodness. No account can be given of what makes an action right until it is established what is valuable, or good.⁴¹ Any monistic conception of good is rejected: virtues are irreducibly plural.⁴² Any tie to desires is rejected: virtues are objectively good, irrespective of whether we wish to have them or

³⁸ From the Greek *arete* – the goodness or excellence of a thing. As used by D. Statman, in *Virtue and Ethics: A Critical Reader*.

³⁹ ‘Varieties of Virtue Ethics’, (1996) *Ratio* 9 128-152.

⁴⁰ So persuasive has this insistence been that it is adopted into more recent forms of utilitarianism and Kantianism. For example Barbara Herman argues that the categorical imperative is best understood as a normative disposition in the character of a good agent to rule out certain courses of conduct as impermissible: *The Practice of Moral Judgment*, (Cambridge MA: Harvard University Press, 1993).

⁴¹ Virtue ethics, when properly understood, thereby avoids the objection of circular logic (as advanced, for example by Edmund Pellegrino). “It does not specify right action in terms of the virtuous agent and then immediately specify the virtuous agent in terms of right action. Rather it specifies her in terms of the virtues, and then specifies those, not merely as dispositions to right action, but as the character traits...required for eudaimonia” Rosalind Hursthouse, ‘Virtue Theory and Abortion’ (1991) 20 *Philosophy and Public Affairs* p 226.

⁴² Oakley’s fourth claim, clearly distinguishing virtue ethics from the older forms of utilitarianism.

not.⁴³ Some virtues are agent-neutral, like justice, but others are agent-relative, like friendship.⁴⁴ Finally, acting rightly does not require that we maximise the good.

Virtue ethics is a broad church. There are different interpretations of the nature of virtue, the ethic's key element, even among proponents of the theory.⁴⁵ The most prominent approach adopts an Aristotelian view, whereby virtues are those character traits which mankind needs to develop if we are to flourish and prosper in life,⁴⁶ but *eudaimonia* is an obscure concept, seldom discussed in the queue for the Clapham omnibus. Others advance distinctly different but equally complex foundations: Alasdair MacIntyre's historicised view looks for dispositions necessary to maintain communal practices, like trustworthiness. Michael Slote takes the most practicable approach, looking simply for those character traits which we typically find admirable, like kindness, but even this admits subjective confusions.

However obscurity and complexity are not exclusive to virtue ethics. Competing theories suffer the same limitation. Both *happiness* and *rationality*, as they figure in utilitarianism and Kantianism, are rich and difficult concepts⁴⁷ – hence all the disputes about their meaning. The distinction is really in the plurality, which appears to leave virtue ethics vulnerable to subjectivism and emotism. In an age of moral diversity there is an enormous range of virtues⁴⁸ from which to choose.

⁴³ Oakley's fifth claim, which distinguishes virtue ethics from some forms of utilitarianism.

⁴⁴ Oakley's sixth claim, which distinguishes virtue ethics from most forms of consequentialism.

⁴⁵ But this is not a problem unique to virtue ethics. Proponents of rival theories have equivalent disagreements too, as we have already seen.

⁴⁶ "Eudaimonia" is the Aristotelian term for it, the meaning of which is best conveyed by flourishing/being happy/successful. The necessary virtues include honesty, integrity, courage, justice, benevolence, compassion and the like. Rosalind Hursthouse takes this approach; Phillipa Foot develops it to a functionalist level, identifying virtue not so much in the idea of a good human being as in what is good *for* human beings.

⁴⁷ As is pointed out by Rosalind Hursthouse in her vigorous defence of virtue ethics, 'Virtue Theory and Abortion'.

⁴⁸ P. Gardiner neatly encapsulates the diversity on offer with a thumbnail sketch of differing selections of virtue: Ancient Greek philosophers expounded virtues of courage, prudence, temperance and justice; Christian theology focuses on virtues of faith, hope and charity; Beauchamp and Childress consider that the five virtues applicable to the medical practitioner are trustworthiness, integrity, discernment, compassion and conscientiousness. ('A Virtue Ethics approach to Moral Dilemmas in Medicine' (2003) *J Med Ethics* 297 at 298.

Finding a match in the understanding of virtue between the subject and the object of any given action becomes a matter merely of happenchance.

Moreover, areteic approaches have to struggle with “a major problem of cultural relativism.”⁴⁹ Perception of virtue can change over time and across cultures: the heroic virtues of Homer are very different to the gentler virtues of Christianity. Even within a given context (say the practice of medicine), the necessary virtue set is not fixed. Robert Veatch thinks it is not going too far to say that “one could have virtually any set of virtues one wanted...simply by picking the cultural tradition and time period properly.”⁵⁰

On the other hand, as long as there is sufficient clarity in any particular time, adaptability over time may be a strength as well as a weakness. Medical decisions have to be taken over very short time frames, not millennia; and scientific developments need to be accommodated rapidly. If we try to determine the virtues relevant to Britain at the beginning of the twenty-first century, using any of the modern approaches of virtue ethics, it is possible to draw up a lengthy list. Whilst not every virtue appears on every list, there is presently a substantial degree of convergence, such that Gert felt confident to declare in 1985 that “when the terminology is adequately explained, there is virtually complete agreement on the nature of virtues and vices.”⁵¹

More interesting is the criticism that, however the list is fixed, virtue will never be an adequate guide to action, because it answers the question “what sort of person should I be?”, rather than the question “what should I do?” Virtue ethics cannot therefore be a normative rival to deontology or utilitarianism. There are implicit in this criticism two issues: whether the primacy of character precludes formulation of behaviour guides, and the nature of the connection between virtuous character and right action.

⁴⁹ AV Campbell ‘The Virtues (and Vices) of the Four Principles’ (2003) *J Med Ethics* 292 at 292

⁵⁰ ‘Against Virtue: a Deontological Critique of Virtue Theory in Medical Ethics’, in Earl E. Shelp (ed), *Virtue and Medicine*, at page 334. He is not alone in this type of criticism. Specifically in the medical context, Pellegrino and Thomasma pursue similar arguments in *The Virtues in Medical Practice*.

⁵¹ Bernard Gert, ‘Virtue and Vice’, in Earl E. Shelp (ed) *Virtue and Medicine*, at page 95.

Rosalind Hursthouse answers the first issue, almost dismissively:⁵² every virtue generates a positive instruction (act justly, kindly etc.) and every vice a prohibition (do not act unjustly, cruelly etc.). She calls them the V Rules. The criticism then becomes, not that there is a lack of action guides, but an excess. Different virtues can point in different directions. Honesty prompts me to give a negative opinion; kindness quells it. Where the virtues are in conflict, how can virtue ethics guide decision-makers to right judgments?

It may be argued that the conflict is merely apparent, and would disappear with a fuller moral understanding of, for example, what is involved in acting kindly, but Hursthouse has a more compelling response, which also answers the second aspect of the initial criticism. Put simply, she asserts that virtue ethics does not contend for singular right answers - and neither does it deliver simplistic wrong ones. It allows the possibility of competing virtues,⁵³ and that different actions in the same circumstances may be equally right. Two people may both behave well when resolving the same situation in different ways. "Whether one does what a kind person would have done, or what an honest person would have done, one would still have acted rightly."⁵⁴ To seek the virtue is not necessarily to seek to exemplify it in every situation; sometimes it may be preferable to exemplify a different virtue.

In this way, virtue ethics rejects the modelling of philosophy on scientific theory,⁵⁵ and allows the possibility of moral dilemmas.⁵⁶ The real-world applicability and attraction of this, as seen in the case of *Re A*

⁵² *Normative Virtue Ethics* in Roger Crisp (ed) *How Should One Live? Essays on the Virtues* at p25.

⁵³ As is sought by Stanley M. Hauerwas, 'On Medicine and Virtues: A Response', Earl E. Shelp (ed) *Virtue and Medicine*, *ibid* n24 pp347-355 at 353: "too often the problem is not that we are doing the morally wrong thing in medicine, but that we are not allowing for the possibility of other competing virtues. What is required is the development of an ethos sufficient to support the often conflicting virtues inherent in the practice of medicine."

⁵⁴ *Beginning Lives* (Oxford: Basil Blackwell, 1987), p34

⁵⁵ In science, the purpose of decent theory is to enable us to answer questions that we could not answer before we had it. The representatives of "anti-theory" in ethics reject the idea of normative ethical theory. Proponents include Baier, McDowell, MacIntyre and Nussbaum, but not actually Hursthouse herself.

⁵⁶ Rosalind Hursthouse, 'Normative Virtue Ethics', in Roger Crisp (ed) *How Should One Live? Essays on the Virtues*.

(*Children*)(*Conjoined Twins: Medical Treatment*)(*No. 1*),⁵⁷ is obvious. Ward LJ took care to point out, despite his judgment that separation surgery should go ahead, if the hospital had bowed to the parents' wishes and not sought a court order, that also would have been acceptable.⁵⁸ In such cases, only a fool looks for simple answers; wisdom acknowledges difficulty. Virtue ethicists recognise that tragic dilemmas can rarely be resolved to the complete satisfaction of all parties, and that "any conclusion is likely to leave some remainder of pain and regret."⁵⁹

Equally, the same action may be right on some occasions, but wrong on others – not because its morality varies according to the consequences, but because the fully virtuous agent acts differently according to the circumstances.

And yet, a distinction *may* be drawn between right action and proper motive. As Aristotle himself acknowledged, an action can be right without being virtuous, and an action can only be virtuous if performed from the right state of mind. Motivation of the agent is of crucial importance. That being so, can people of great virtue be misled into wrong action? Veatch⁶⁰ would say so, and worse. He contends that virtue ethics is actually dangerous, because selection of the wrong virtue in the absence of an ethical principle or moral rules or institutional checks to govern one's acts tends to induce wrong action, freeing up agents to "sin bravely", on the conviction that their motives are good. So, Eichmann may well have been sincere, persevering and even courageous in his determination to ensure the gassing of his Jewish victims, but he was certainly not virtuous.⁶¹ Moreover naked virtue leads to other detrimental effects as well, such as over confidence, disinclination to submit to peer or public monitoring and, if others are convinced of the virtue, lax regulation of conduct.

⁵⁷ [2001] 2 WLR 480

⁵⁸ "Just as the parents hold firm views worthy of respect, so every instinct of the medical team has been to save life where it can be saved. Despite such a professional judgment it would, nevertheless, have been a perfectly acceptable response for the hospital to bow to the weight of the parental wish however fundamentally the medical team disagreed with it. Other medical teams may well have accepted the parents' decision. Had St. Mary's done so, there could not have been the slightest criticism of them for letting nature take its course in accordance with the parents' wishes.", per Ward LJ at page 173

⁵⁹ P. Gardiner 'A Virtue Ethics Approach to Moral Dilemmas in Medicine' (2003) *J Med Ethics* 297 at 301.

⁶⁰ Robert M. Veatch, *ibid* n 24 at p329-345. He poses the "naked virtue problem", p335.

⁶¹ AV Campbell 'The Virtues and Vices of the Four Principles' (2003) *J Med Ethics* 292 at 293.

Slote would question whether a genuinely virtuous act could indeed be “wrong”, but other theorists argue the point from the other end, and question whether virtue can really be said to be present. Justin Oakley denies the sufficiency of virtuous motivation, contending that virtue has a practical component, which involves ensuring that one’s action succeeds in bringing about what the virtue dictates. In this way, virtue ethics does not condone moral ineptitude. “There is more to having a virtue than meaning well.”⁶²

That being so, knowing what it is that having a virtue entails is a difficult thing, but it is critical to the practicability of virtue ethics. In any discussion of real moral issues, the virtue ethicist is obliged to judge: to say whether a certain act is honest, dishonest, or neither; charitable, uncharitable or neither.⁶³ Life being what it is, such judgments are not always easy. Difficulty in application limits the attraction and adoption of a theory, but says nothing of its sufficiency, unless we expect moral theory to make hard things easy – an implausible test. As Aristotle recognised and Hursthouse calls in support,⁶⁴ moral knowledge, unlike mathematical knowledge, cannot be acquired by attending lectures and is not characteristically to be found in people too young to have had much experience of life.

This raises the practical question of how, if we are to adopt virtue ethics as a normative guide beyond the private sphere, the virtuous character of public servants – like doctors and judges - can be assured. As Meno asked Socrates, is virtue something that can be taught? Does it come by practice? Pellegrino and Thomasma suggest that the teaching of ethics “does sensitise students to what constitutes an ethical issue or problem.....it forces self-criticism and examination of one’s own values. It demands that reasons be given for moral choices, that

⁶² Jennifer Jackson, *Ethics in Medicine* (Malden MA: Polity Press, 2006) at p11.

⁶³ As Bernard Gert points out, it is not necessarily the case that everyone either has the virtue or the vice and that no one has neither. Many people are neither courageous nor cowardly, neither truthful nor deceitful (*ibid* n25 at p97).

⁶⁴ Rosalind Hursthouse, ‘Normative Virtue Ethics’, in Roger Crisp (ed) *How Should One Live? Essays on the Virtues* at p 230.

opposing viewpoints be given an adequate response....”⁶⁵ History, in the shape of the Nazi doctors, shows that ethical training offers no guarantees. For that reason, however desirable virtue as a personal trait, it makes an unsafe basis for the formulation of public policy.

Returning to our case studies, Annie needs to be treated with kindness and compassion. Acting virtuously, her doctors would approach the issue of surgery with a humble regard for the practical issues of severe disability, and a willingness to accept that these issues may point them in a different direction to straightforward clinical considerations.

Bella’s doctors need practical wisdom to guide their actions in the light of all the circumstances of her case, assessing her physical needs in the light of her age and maturity, her considered ambition and her understanding of its consequences. What may have been the right thing to do for their last patient with eating issues, may not be the right thing in Bella’s case. Putting their conclusions into action may require patience and courage, either to administer nutrition when there is resistance, or to watch her physical condition deteriorate.

It is more difficult to see the requirements of virtue in Cecil’s situation. It would be kind to Cecil and his daughters to act so as to maximise mobility and minimise dependence. If Cecil does not consent to the operation, the virtuous doctor would therefore try to persuade him to change his mind. If that did not succeed, the virtuous doctor would be torn between wanting to act kindly, and wanting to act respectfully of his wishes.

Annie, Bella and Cecil show us that virtue ethics soothes our moral conscience more effectively than it guides our practical actions. In difficult situations, it is reassuring, and confidence-inspiring, to know that those who hold our health in their hands will act well; but it does not tell us with any certainty what they will do. Trusting ourselves to their virtue also leaves us vulnerable to those who abuse our trust. The termination of the reproductive potential of a severely

⁶⁵ *The Virtues in Medical Practice* at p 179.

disabled girl in the interest of continuing her loving care, is surely morally distinguishable from the sterilisation of mental defectives to avoid the repetition of their genes, but it may not always be easy to prove on which side of the line any given case falls. Motivation is subjective and may be dissembled. Virtue is indispensable as a private ethic, but insufficient as a public one.

Relationship based theory

The *ethics of care* take a different approach to life. Whereas as the other theories we have considered, whatever their central focus, tackle moral issues within the province of individuals, the ethics of care emphasise relationships and locate moral issues in the context of interdependency.

The intellectual roots of the ethics of care are in psychology, rather than philosophy, and feminist psychology in particular. In 1982, Carol Gilligan published her ground-breaking work, *In a Different Voice*. Previously mainstream psychology had chosen, like Virgil, to “sing of arms and the man”, and philosophical development of the subject, such as the work of Lawrence Kohlberg,⁶⁶ had reflected that. Insofar as any psychological studies had included women at all, the different data they produced was generally dismissed as a deviation from the norm, an aberration. Gilligan set about redressing the balance by looking specifically at the psychological development of women, to call attention to what was missing in the generally accepted account. Seen in this light, the discrepant data on women’s experience “provided the basis from which to generate new theory, potentially yielding a more encompassing view of the lives of both sexes.”⁶⁷

⁶⁶ Lawrence Kohlberg developed a theory about how people reason and develop morally. He posited that people applied principles to particular cases, to come up with moral judgments: *The Philosophy of Moral Development* (1981)

⁶⁷ ‘In a Different Voice’ (Cambridge MA; Harvard University Press, 1982) p4

Jean Baker Miller⁶⁸ had already suggested that psychological development followed a different path for men and women. She noted that women's sense of self was organised around being able to make and then maintain affiliations and relationships. Conventionally dismissed in terms of inequality and oppression, Miller saw instead a development which did not displace the value of ongoing attachment. In continuing care and connection she saw the potential for more advanced, more affiliative ways of living, but she found no language in psychology to describe it. Gilligan filled the void. She reinterpreted women's experience in terms of their own imagery and described, instead of a hierarchy, a *web of relationships*, as a metaphor for interdependence and connectedness.

Gilligan illustrates her findings and how they differ from Kohlberg's approach by asking two 11 year olds, Jake and Amy, to resolve Heinz's dilemma. Heinz's wife needs a drug, but Heinz cannot afford to buy it and the pharmacist will not give it to him. Should Heinz steal it? Jake quickly answers that he should, justifying his response by appeal to the relative importance of life over property. Amy begins equivocally. She points out that if Heinz steals it, life could get worse – he could be imprisoned, leaving his wife without a carer. She suggests that Heinz and the pharmacist should sit down and work out a mutually satisfactory solution. For Jake, the problem is cognitive: he reasons about the situation, and acts accordingly, just as Kohlberg posits. For Amy, the only real solution involved a growth in moral sensitivity and commitment. Gilligan saw these as different moral orientations, and she called them the voices of justice and of care.

This vision gave rise to an ethic predicated on care and concern, rather than rights and fairness. Manning has identified five central ideas.⁶⁹ Firstly, a care approach requires moral attention – a willingness to attend to the full complexity of any particular situation. Secondly it requires sympathetic understanding – an openness to empathy and identification with others, and a willingness to see what others would want. Thirdly, it is aware of relationships – specifically the

⁶⁸ 'Toward a New Psychology of Women', (Boston: Beacon Press, 1976)

⁶⁹ Rita C. Manning, 'A Care Approach' in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics* (Oxford: Blackwell Publishers, 1998) p98-99

relationship with the moral decision maker, be that from a particular role (doctor, judge) or simply as a fellow member of the human race; but also the wider network of relationships within which the other operates. It sees moral agents as embedded in particular social contexts and personal narratives. Fourthly, it makes accommodations. It is not always possible or wise to do what everyone thinks they need, but often it is possible, whilst doing what one thinks best, to give everyone concerned a sense of being properly considered in the process. Finally, it requires response: the approach must be made concrete by corresponding action.

Put together in a holistic approach, these ideas amount to a view of humanity which stands in clear contrast to established philosophical approaches. By overemphasising detached fairness traditional approaches, it says, have lost sight of reality and what matters to us most. We are born utterly dependent on others; and many of us will return to that condition before we die. In between, “whether or not we like it and regardless of how we regard it, caregiving labor...is the work we do that creates the relationships, families, and communities within which our lives are made pleasurable and connected to something larger than ourselves.”⁷⁰ Care is to be valued, and interdependency is inevitable. Within caring relationships, our visions of ourselves must be fluid:⁷¹ “we” cannot easily break down into “you” and “I”. As Claire, one of the college students in Gilligan’s study⁷² put it, “By yourself, there is little sense to things. It is like the sound of one hand clapping.”

Tackling moral issues, the ethics of care therefore takes a relational approach. The key question is not whether it is my right to do X, but what is my proper obligation within the context of this relationship? The skill is not to balance competing claims, but to determine responsibilities within mutually supporting relations. “An ethic of care focuses on attentiveness, trust, responsiveness to need, narrative nuance, and cultivating caring relations. Whereas an ethic of

⁷⁰ Robin West, ‘The Right to Care’, in E. Kittay and E. Feder (Eds.), *The Subject of Care: Feminist Perspectives on Dependency*, p89.

⁷¹ Jonathan Herring, ‘Where are the Carers in Healthcare Law and Ethics?’ (2007) 27 *Legal Studies* 66.

⁷² ‘In a Different Voice’ p160.

justice seeks a fair solution between competing individual interests and rights, an ethic of care sees the interests of carers and cared-for as importantly intertwined rather than as simply competing.”⁷³

Agent relativism is therefore inherent in the ethics of care. It agrees that all persons are valuable, but it recognises special obligations: those imposed by actual or potential relationships and roles. Since it understands communities as more than mere aggregates of individuals, and relationships as more than properties of individual persons, it is committed to saying that communities and relationships have moral standing. So, obligations to family and friends are stronger than obligations to strangers. It may therefore be of particular pertinence to issues of health and medical decision-making. It both recognises and guides the relationship between patient and decision-maker. Moreover, in requiring responsiveness to another’s needs *as that other sees them*, it provides a counter-balance to the assumption that a narrow *medical* good will always best meet those needs.

From a traditional perspective, the insistent contextual relativism of the care approach appears inconclusive and diffuse. It has been dismissed as inherently vague and capable of justifying almost any plausible moral argument,⁷⁴ but Herring⁷⁵ points out that the same could be said of other respected approaches and concepts. Moreover emphasis on the emotional dimension of moral life does not reduce moral response to emotional response. Caring also has a cognitive dimension: it involves insight into and understanding of another’s circumstances, needs and feelings, and it is this which directs us in choosing how to act. Herring compares an ethic of care with the concept of rights: both provide ethical tools with which to analyse a situation, but neither provides an answer. We have already seen that this is not fatal to the adequacy of a moral approach: the ethic of care can simply align itself with virtue ethics, warning against anything which purports to offer simple answers to complex issues.

⁷³ Virginia Held, *The Ethics of Care* (Oxford: Oxford University Press, 2006) p15

⁷⁴ Emily Jackson, *Medical Law*, p22

⁷⁵ ‘Where are the Carers in Healthcare Law and Ethics?’ (2007) 27 *Legal Studies* 66 at p69.

More stringent has been the concern of feminists that an ethic of care perpetuates gender inequality. The criticism stems from its origin in psychology: care, rather than a moral ethic, is an approach forced upon women by generations of social oppression. Susan Sherwin explains that:

“Because gender differences are central to the structures that support dominance relations, it is likely that women’s proficiency at caring is somehow related to women’s subordinated status. Within dominance relations, those who are assigned the subordinate positions, that is those with less power, have special reason to be sensitive to the emotional pulse of others, to see things in relational terms, and to be pleasing and compliant. Thus the nurturing and caring at which women excel are, among other things, the survival skills of an oppressed group that lives in close contact with its oppressors.”⁷⁶

Hence feminists caution against valorising the traits that replicate, maintain and reinforce patterns of domination and subordination.

Perhaps for this reason, those proponents of the ethic of care who have led its more recent development tend to refute any suggestion of gender dependency. Manning, for example, baldly asserts that “we all have an obligation to be caring persons, not in virtue of our gender or our job description, but because we are human beings”.⁷⁷ At the same time, repeats of Gilligan’s (North American) experiments in European countries have not replicated the link she found between gender and differing ethical response.⁷⁸ There is good reason to assert, in liberation of Gilligan’s theory and women in general, that an ethic of care can and should be adopted universally.

⁷⁶ S. Sherwin, ‘Ethics, Feminine Ethics and Feminist Ethics’ in D. Shogan (ed.), *A Reader in Feminist Ethics*.

⁷⁷ ‘A Care Approach’ in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics* at p103. It is regrettable that she somewhat undermines this by choosing, unnecessarily, to call the requirement of sympathetic understanding “maternalism”.

⁷⁸ A. Vikan, C. Camino & A. Biaggio, ‘Note on a Cross-Cultural Test of Gilligan’s Ethic of Care’, (2005) 34 *Journal of Moral Education* 107.

Furthermore, there is no reliance on a sharp distinction between justice and care in a care approach. Gilligan herself saw the two voices of justice and care as complementary, rather than mutually exclusive:

“to understand how the tension between responsibilities and rights sustains the dialectic of human development is to see the integrity of two disparate modes of experience that are in the end connected. While an ethic of justice proceeds from the premise of equality – that everyone should be treated the same – an ethic of care rests on the principle of non-violence – that no one should be hurt. In the representation of maturity, both perspectives converge in the realisation that just as inequality adversely affects both parties in an unequal relationship, so too violence is destructive for everyone involved. This dialogue between fairness and care not only provides a better understanding of relations between the sexes but also gives rise to a more comprehensive portrayal of adult work and family relationships.”⁷⁹

It is therefore perfectly plausible for an ethic of care to promote not relationships indiscriminately, but only relationships which are just.

Rather than taking fright from the psychological origins of the ethic of care, feminist critics could instead have emphasised how Gilligan’s analysis includes responsibility to *self* as well as others. She traced how the concept of rights became absorbed into the thinking of college students in the 1970s, expanding the notion of care “from a paralyzing injunction not to hurt others to an injunction to act responsively toward self and others and thus to sustain connection”.⁸⁰ Consideration of relationships necessarily implies viewing them from both sides. What emerges is an ethic of care with justice: the vision that self and other will be treated as of equal worth; that despite differences in power

⁷⁹ ‘In a Different Voice’ p 173

⁸⁰ ‘In a Different Voice’ p 149

things will be fair; that everyone will be responded to and included, that no one will be left out or hurt.

A more modern concern is that an ethic of care can valorise caring.⁸¹ In the real world, it is all too easy for abuse to be perpetrated on vulnerable people under the guise of care: our “care homes” for the elderly, the mentally ill, and the unparented probably earn more column inches of publicity for abuse than for any positive achievements. Focus on relationships should not allow us to ignore the impact relationships have on the individuals party to them; nor to overlook the need to guard against unjust relationships.

Returning to our case studies, for Annie the need to maintain the relationship with her parents is crucial. She is absolutely dependent on them; and their response to her so far has been devoted and caring. Their ability to continue to offer her the best care depends on them being able to manoeuvre her physically. The proposed medical intervention would help to sustain the relationship.

The nature of the relationship between Bella and her parents may be instrumental to her attitude to food. The ethic of care demands that doctors attend to the full complexity of it: is there a psychological issue of power that needs to be accommodated? It will be particularly important to ensure that Bella feels properly considered in the process of determining how the eating issue is to be tackled, even if the conclusion does not support her declared ambitions. The way in which the medical issue is approached could be destructive, or restorative, of the family relationships, and in that way even tackle the underlying issues behind the need for medical treatment.

Cecil’s much-vaunted “independence” would be short-lived without the support of his daughters. They are unlikely to withdraw their support lightly, because of the long family narrative, but equally they cannot be expected to shoulder unlimited burdens. The consideration of their needs is legitimate, such that Cecil has a responsibility to do all that he can to ensure that the relationship remains

⁸¹ See Herring ‘Where are the Carers in Healthcare Law and Ethics?’ (2007) 27 *Legal Studies* 66.

just and non-abusive, and that may include overcoming reluctance for surgery. If the network of relationships is taken seriously, any right to refuse consent to treatment may yield to responsibilities towards others, especially where the stakes for the patient are relatively low and the cost of the alternative to others is relatively high.⁸²

Annie, Bella and Cecil show us that an ethic of care *can* point to practical solutions, but we have been able to see that only because our case studies are fictional, and it is therefore open to us to infer background details beyond the known facts of the case. We can infer that Annie's parents have cared for her devotedly and will continue to do so as long as they are physically able; that Bella is struggling for control of some aspect of her life; and that Cecil will accept the responsibilities of justice in relationships. For doctors and courts making real treatment decisions, divining the true merit of the web of interdependence, so that support will be engendered but abuse not perpetuated, may not be so easy.

Principle based theory

The dominant model of medical ethics for the last 30 years or so has been principlism, as laid out in the seminal text of Beauchamp and Childress, *Principles of Biomedical Ethics*, now in its fifth edition. Principlism is constructed on an analytical framework which is said to express the underlying rules of commonly accepted morality⁸³ in four clusters of principles, which then

⁸² Nelson & Nelson give an example, set in a financial context unfamiliar to UK healthcare, but illustrative nonetheless: "If..a kidney stone can be removed by catheterisation for a fraction of what it costs to have it pulverised by lithotripsy, and if the family is uninsured for lithotripsy, the patient may be justly censured for insisting that the family's savings be wiped out simply so that he may refuse catheterisation." (*A Patient In The family*, p113). John Hardwig goes further: "In many cases family members have a greater interest than the patient in what treatment option is exercised. In such cases, the interests of family members ought to *override* those of the patient....To be part of a family is to be morally required to make decisions on the basis of thinking about what is best for all concerned, not simply what is best for yourself." (*What About the Family?* Hastings Center Report 20 (1990) p5-10.

⁸³ Whether this is in fact true is a matter of debate. For instance H Tristram Engelhart Jr. and Kevin William Wildes argue that there is no such set of commonly held norms in modern, pluralist societies. Our world, they say, is composed of "moral strangers" who do not share a moral vision.

serve as guidelines for ethical conduct in the medical setting. The four clusters are *respect for autonomy* (a norm of respecting the decision-making capacities of autonomous persons); *nonmaleficence* (a norm of avoiding the causation of harm); *beneficence* (a group of norms for providing benefits and balancing benefits against risks and cost); and *justice* (a group of norms for distributing benefits, risks and costs fairly). Either alone or in combination, it is said⁸⁴ that these four principles can explain and justify all the substantive and universalisable claims of medical ethics.

Principlism established itself as the standard medical ethic so universally and so quickly because it is tailor-made for the context and for minimum controversy. Apparently reducible to four easily memorised “soundbites”, it is broadly compatible with almost any of the great intellectual theories whilst avoiding their less palatable implications; and two of them are identical to the obligations of the Hippocratic Oath.⁸⁵ It is specific enough to reduce the subjectivity of ethical debate, and to indicate paths of action. It offers a moral methodology readily accessible to health professionals, analogous to a clinical workup of a diagnostic or therapeutic problem. And it avoids direct confrontation with the divisive issues of abortion, euthanasia and reproductive technologies.⁸⁶

However, there is vigorous dispute as to the philosophical credentials of principlism. The general thrust of the criticism is that principlism is mistaken about the nature of morality and misleading as to the foundations of ethics. K. Danner Clouser and Bernard Gert,⁸⁷ for example, contend that the principles function neither as adequate surrogates for moral theories nor as directives for determining morally correct action. They do not function (as do the principles of

⁸⁴ By R Gillon: ‘Ethics Needs Principles – Four Cane Encompass the Rest – And Respect for Autonomy Shall Be First Among Equals’ (2003) *J Med Ethics* 307 at 307. He makes a plea for this to be not denigrated as ethical imperialism, but celebrated as ethical ecumenism.

⁸⁵ Beneficence and nonmaleficence mirror the Oath’s requirements to act in the best interests of the patient and to avoid doing harm.

⁸⁶ See Pellegrino and Thomasma, *The Virtues in Medical Practice*, p187. More scathingly, Harris describes the four principles as ‘a useful checklist approach to bioethics for those new to the field, and possibly for ethics committees without substantial ethical expertise’: ‘In Praise of Unprincipled Ethics’ (2003) *J Med Ethics* 303 at 303.

⁸⁷ ‘A Critique of Principlism’, *Journal of Medicine and Philosophy* 15 (1990) 217-236. There are others, such as Barush Brody and Ronald Green, who voice similar concerns

Rawls and Mills⁸⁸), as summaries of the theories that generated them. Rather they are “primarily chapter headings for a discussion of some concepts which are often only superficially related to each other.”⁸⁹

The “chapter headings” do owe much to ethical theories, and in particular those parts of the theories which are most widely supported: beneficence incorporates Mill; autonomy, Kant; justice, Rawls; and nonmaleficence, Gert.⁹⁰ Presenting them as a cluster of principles suggests however that these great philosophies have been integrated into a unified theory, whereas in fact the opposite is true. There is no attempt to show how the different theories can be reconciled or blended together into a single adequate theory. Instead a pluralist approach is taken: rival theories are reduced to a checklist of considerations, with no moral theory to tie them together. As a result there is no unified guide to action which can generate rules, and therefore no justification for any rules. The agent is left to pick and choose from the checklist as she sees fit.

The problem with this approach is the false sense of moral security which it engenders. A “principle” is assumed to be firmly established and justified, and therefore authoritative. The agent is therefore likely to believe that she is applying a well-developed, unified theory, when in fact she is unwittingly drawing on several diverse and conflicting accounts. She is thereby deprived of any secure moral ground for her action. She will not know what fundamental assumptions and ideals are inherent in her approach; she will therefore not be able to tell which are the relevant facts, or how to apply the correct approach to them. In its apparent simplicity, it creates a false confidence in ethical decision making abilities.

(i) Autonomy: Against this background falls to be assessed principlism’s most significant contribution to the ethics of medical decision-making: the emphasis

⁸⁸ For Rawls, see *A Theory of Justice* (1971), *Political Liberalism* (1993) and *The Law of Peoples* (1999). For JS Mill, see *Utilitarianism* (1861), *A System of Logic* (1843) and ‘*On Liberty*’ (1859).

⁸⁹ Danner Clouser & Gert, ‘A Critique of Principlism’, *Journal of Medicine and Philosophy* 15 (1990) 217 at p221.

⁹⁰ Beauchamp and Childress acknowledge this: “Our goal is to eliminate what is unacceptable in each type of theory, and to appropriate what is relevant and acceptable.”

on autonomy. The term “autonomy” derives from ancient Greek: ‘autos’ meaning self, and ‘nomos’ denoting rule, governance or law. It was applied by the ancient Greeks to city-states that were politically independent; so its modern application to individuals relies on a metaphor.

Jennifer Jackson has identified three senses in which individuals can be autonomous.⁹¹ On one level, being autonomous is equivalent to being free, unconstrained by others (“the liberty sense”). Alternatively, being autonomous is equivalent to being in control of oneself, able to make decisions and act in line with them (“the self command sense”). Finally, autonomy is about independence, making decisions on one’s own, not on the advice or direction of others (“the self-reliance sense”).

Beauchamp and Childress refer to the last, self-reliance sense. They analyse autonomous action in terms of normal choosers who act *intentionally*, with *understanding*, and without *controlling influences* that determine their action.⁹² While intention is an absolute requirement, reality dictates a concession that perfect understanding and freedom from constraint are rarely achieved; so all that principlism requires is “a substantial degree” of autonomy, assessed in the light of specific objectives.⁹³

The philosophical origins of respect for autonomy span both deontology and utilitarianism. Kant’s principle of humanity insists that people are morally different to things because they have rational capacity, which allows them to be self-determining, and gives them intrinsic value. Therefore people should be treated as an ends in themselves, not merely as a means to someone else’s ends, and accorded respect and dignity. John Stuart Mill’s principle of liberty states that the only purpose for which power can rightfully be exercised over another against his will is to prevent harm to others. His concern with “individuality” demands that society permit persons to develop according to their convictions, as long as they do not interfere with the like expression of freedom by others.

⁹¹ *Ethics In Medicine* at p66.

⁹² *Principles* p59.

⁹³ *Principles* p59.

Despite its philosophical pedigree, the notion of self-determination for *patients* was historically rather a pale one. The gift of principlism has been to build for autonomy a dominance which it previously lacked. Even accepting Jeremy Bentham's contention that doctors must historically have acted within a legal framework which required consent,⁹⁴ the recent notion of partnership in healthcare is in stark contrast to the traditional authoritarianism and paternalism of the medical profession. Doctors hitherto have always held a social position which left most people in awe. As Herring points out, there was nowhere for medical law or ethics to go until there was a serious challenge to medical paternalism.⁹⁵ The focus on the rights of autonomy and bodily integrity⁹⁶ was essential if there was to be a challenge to the supremacy of medical opinion.

The principle of autonomy does indeed operate to restrict healthcare interventions: only those that respect the decision-making capacities of competent patients are allowed. Deception, emotional manipulation, and physical force are clearly prohibited. Paternalism is discredited. Patients make their own decisions, even contrary to medical advice, and physicians' ability to act is limited accordingly. It is not just a respectful attitude which is required, but its practical application in action too. It includes the obligation to build up and maintain, and to remove obstacles to, the autonomy of others.

The principle of autonomy may be heralded for what it achieved in challenging medical paternalism, but latterly it has attracted significant criticism for being elevated out of proportion to its contribution. Although Beauchamp and Childress insist that the autonomy principle is just one in a framework of *prima*

⁹⁴ The alternative hypothesis, that doctors were wont to impose treatment forcibly on their patients (even on adults of sound mind) is incredible. "Distrust and terror would watch by the sick man's bed": Jeremy Bentham, *Theory of Legislation*, p269. Beauchamp and Childress dismiss the absence from the Hippocratic Oath of any mention of consent or respect for self-determination as immaterial: the duty to obtain consent relates to a general duty in law, and is not exclusive to medical law or ethics. "There is, then, no particular reason why it should be included in the Hippocratic Oath, any more than this Oath should make mention of the general duty not to steal." (*Principle of Biomedical Ethics*, p59)

⁹⁵ 'Where are the Carers in Healthcare Law and Ethics?' (2007) *Legal Studies* 66

⁹⁶ Of which Ian Kennedy's Reith lectures and the book which came out of them, *Treat Me Right*, were in the vanguard in the UK.

facie principles, without any priority over the others⁹⁷, later disciples openly celebrate it as “first among equals,”⁹⁸ while critics claim that it is too often assumed to trump the others, so that competing considerations are overlooked.

The corollary of elevating the individual is devaluation of the collective. The family, and wider society, are diminished as institutions of importance. Willard Gaylin and Bruce Jennings⁹⁹ therefore criticise the culture of autonomy as destructive of the foundations of social order, and lacking any conception of responsibility to others.¹⁰⁰ Public health legislation permits the detention of critically infectious individuals suffering from diseases specified diseases, such as tuberculosis. Yet, once immured in hospital, those same individuals may refuse treatment to reduce their contagion.¹⁰¹

Beauchamp and Childress purport to recognise this in their emphasis on the *prima facie* status of the principle, meaning that it can sometimes be overridden by competing moral considerations. They see the principle of autonomy both as an important moral limit and as itself limited; and one of the limitations on it would be when healthcare decisions “enter the realm of other-regarding behaviour, causing or risking harm to others or to the community.”¹⁰² This defence is not compelling: there is nothing inherent in the principle which requires such limitation. As a tactic, it simply illustrates the arguments of K. Danner Clouser and Bernard Gert discussed above.

Donchin goes further, asserting that principlism sets bare autonomy and interpersonal connection as mutually exclusive ways of operating.¹⁰³ The portrayal of the individual in the culture of autonomy relies on an idealised

⁹⁷ *Principles* p104

⁹⁸ Even, by R Gillon, in an article which bears that boast in its title: ‘Ethics Needs Principles – Four Can Encompass the Rest – and Respect for Autonomy Should be “First Among Equals”’ (2003) *J Med Ethics* 307: “Autonomy as *primus inter pares*...is what makes morality – any sort of morality – possible.” (p310)

⁹⁹ See *The Perversion of Autonomy* (1996).

¹⁰⁰ See also Draper & Sorell’s ‘Patients’ Responsibilities in Medical Ethics’ [2002] *Bioethics* 335.

¹⁰¹ See Margaret Brazier, ‘Do No Harm – Do Patients Have Responsibilities Too?’ [2006] *Cambridge Law Journal* 397

¹⁰² *Principles* p65, p274

¹⁰³ Anne Donchin, ‘Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethical Principles’, *Journal of Medicine and Philosophy* 2001, 26 no. 4. p 368 at p375

image of the rational patient, calculating from a list of social goods and freely choosing among them. The model patient is typically a male in the prime of life who meets the physician as his intellectual and moral equal; and the physician is free to act without external constraint. It implies a model of physician-patient encounter most likely to arise in acute illness: they meet episodically, and their relationship is structured around the need to decide on a course of treatment. Once the decision is made and implemented and the patient is restored to health, they go their independent ways again.

Such an image of self-containment is a bleak one, where all social ties have come undone, in stark contrast to an ethic of care. It is also divorced from reality. Real patients do not match the idealised image, for the context of illness has been lost. There is no acknowledgment of the destabilising effect of illness on personality: confidence, judgment and assertiveness desert most of us (even those who start closest to the image) as pain and fear take hold. In illness, it becomes apparent that individuation is a fragile achievement, always at risk of unravelling. We turn to others more, not less. So the separateness demanded by the bare autonomy model is impossible to achieve – and it is not clear why patients should even try, unless interdependence is seen as a condition to be overcome.

The autonomy model fails to acknowledge that illness is disruptive of life, not just for the patient but also for her family, who are expected to provide care until health is restored and the threads of life can be picked up again. The impact on their lives is simply overlooked, even though (as we have seen in chapter 1) empirical evidence demonstrates both that patients with good family support have better post-operative outcomes¹⁰⁴ and that one family member's illness has an adverse effect on the wellbeing of others.¹⁰⁵ Excluding any recognition of responsibility to others sets autonomy against justice, at least to those others.

¹⁰⁴ H Lindemann Nelson and J Lindemann Nelson, *The Patient In The Family*

¹⁰⁵ C. Teri, 'Behavioural problems in patients with Alzheimer disease and its associations with caregiver distress' (1997) Supp4 *Alzheimer's Disease and Associated Disorders* 35; RG Longsdon et al, 'Wandering: a significant problem among community-residing individuals with Alzheimer's disease' (1998) B53(5) *J Gerontology* 294

Beauchamp and Childress reject these criticisms as misguided. Their concept of autonomy is, they say, “not excessively individualistic (neglecting the social nature of individuals and the impact of individual choices and actions on others), not excessively focussed on reason (neglecting the emotions), and not unduly legalistic (highlighting legal rights and downplaying social practises).”¹⁰⁶ By way of proof, they point to their concession that understanding and freedom from constraint are spectrum conditions. Going further, they also accept that capacity for autonomy, and exercise of autonomy are not necessarily co-existent; that even persons capable of self-governance may sometimes fail to act that way because of temporary constraints, of which the stress and fear induced by significant illness must be an instance.¹⁰⁷

Beauchamp and Childress cater for this by concentrating on the decision-making and “autonomous choice” (rather than – as some theories do – the traits of autonomous persons), and balancing the principle of respect for autonomy with a correlative *right*, not *duty*, to choose. Defensively they say, “far from abandoning or supplanting the commitment to respect individual autonomy, this recommendation accepts its central condition that the choice is rightly the patient’s.”¹⁰⁸ Gillon goes further, insisting that since people’s cultural environments influence their autonomous beliefs, respect for autonomy contingently builds in a moral requirement to respect both individual and cultural variability.¹⁰⁹ Therein lies the fault: ultimately, the defence does not meet the criticism. Although it appears to accept that individuals operate only within a context, it sees that as a matter of choice, not as an inescapable – and valuable – part of being human.

A proper answer to the criticism demands a much broader understanding of autonomy that strikes a balance between the individual and the community. As a

¹⁰⁶ *Principles* p57. Beauchamp and Childress are free to maintain this, because there is nothing inherent in the principle to define our approach to autonomy - K. Danner Clouser and Bernard Gert’s argument again.

¹⁰⁷ *Principles*, p58

¹⁰⁸ *Principles* p62

¹⁰⁹ ‘Ethics Needs Principles – Four Can Encompass the Rest – and Respect for Autonomy Should be “First Among Equals”’ (2003) *J Med Ethics* 307 at 311.

communitarian¹¹⁰ Charles Taylor,¹¹¹ for example, argues that the type of autonomy valued by liberals cannot be developed in the absence of family and community structures. John Hardwig¹¹² argues that autonomy should be seen as the *responsible* use of freedom, which is diminished whenever one ignores, evades or slights one's responsibilities. Candace Cummins Gauthier¹¹³ proposes the virtue of moral responsibility in the exercise of self-determination. Jennifer Nedelsky¹¹⁴ reconfigures autonomy to reflect not just the individual, but also the social nature of human beings. All of these interpretations of autonomy incorporate expectations on the part of the patient. Principlism does not rule that out, but it does not espouse it either.

Instead Beauchamp and Childress expand their ability to be caring by limiting the application of the principle. Intervention need not require the consent of the non-autonomous person. The specification of "normal choosers" allows them to exempt persons who cannot act in a sufficiently autonomous manner because they are "immature, incapacitated, ignorant, coerced or exploited"¹¹⁵. The intention may be protective, but each of these terms is subjective and amorphous; their margins are blurred. When does rational choice of authority tip over into coercion?¹¹⁶ How do we know when a patient still lacks maturity?¹¹⁷ A philosophical – and practical - understanding of competence is required.

¹¹⁰ Communitarianism lacks a systematic account, but the emphasis is generally on the influence of society on individuals and the rooting of values in communal history, traditions and practices. What an individual should do is determined by the social role assigned to/acquired by her as a member of the community. Understanding a particular set of moral rules depends on understanding the community's history, co-operative life and conception of social welfare.

¹¹¹ *Sources of the Self: The Making of Modern Identity* (1989)

¹¹² 'What about the family?' *Hastings Center Report* 1990; 20(2):5-10; 'SUPPORT and the invisible family', *Hastings Center Report* 1995; 25(6):S23-5; 'Is there a duty to die?' *Hastings Center Report* 1997; 27(2): 34-42

¹¹³ 'The virtue of moral responsibility in healthcare decisionmaking', (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 273-281

¹¹⁴ 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' [1989] *Yale Journal of Law and Feminism* 7: "The autonomy I am talking about does remain an individual value, a value that takes its meaning from the recognition of (and respect for) the inherent individuality of each person. But it takes its meaning no less from the recognition that individuality cannot be conceived of in isolation from the social context in which that individuality comes into being", p35.

¹¹⁵ *Principles* p65

¹¹⁶ Beauchamp and Childress accept that individuals can exercise their autonomy in choosing to accept an institution, tradition or community as a legitimate source of direction: *Principles* p60. This is relevant for example in the many cases of Jehovah's Witnesses refusing blood transfusion.

(ii) Competence: The simple meaning of competence is the ability to perform a task. The nature of the task determines the skills required to achieve it. For example, competence to make a cup of tea is quite different to competence to build a nuclear bomb. If we were to list the skills required (the “criteria” for competence) to do both tasks, the lists would not be the same. Competence is therefore relative to a particular task. In the context of medical decision-making, competence centres upon the ability to understand a therapeutic procedure, to weigh up its relative risks and benefits, and make a decision in the light of those considerations.

The assessment of competence becomes controversial when risk is thrown into the equation. Some medical decisions, for example having a strained wrist bandaged, carry little risk whichever way the decision is taken. Others, like open heart surgery, carry considerable risk. The higher the risk, the greater the impulse to protect the vulnerable from themselves, and hence the more likely it is that competence will be questioned if anyone who makes a decision contrary to the objectively expected ‘norm’.

It is possible to devise strategies to connect standards of competence to real levels of experience, maturity, responsibility and welfare. Grisso and Applebaum’s competence balance scale,¹¹⁸ for example, adjusts the level of competence required according to the consequences of acting according to the decision: the greater the risk relative to other alternatives, the greater the level of communication, understanding, and reasoning skills required for competence to take that decision. So a young person may be competent to decide whether to

¹¹⁷ Maturity is loosely connected to age. Most people are keen to protect the young and inexperienced from risk. The protective urge to ensure good outcomes for them becomes expressed in the use of age as a criterion for judging competence to make decisions. It is a criterion with which the law is familiar, but it is depersonalised and cannot escape the absurdity of being considered incompetent one day and competent the next simply according to the turn of a calendar.

¹¹⁸ Scales are set up around a fulcrum. An autonomy cup is suspended from one arm of the scale, and a protection cup on the other. The fulcrum is set so as to give more weight to the autonomy cup. The balancing judgment depends on (1) the patients’ abilities in the face of decisional demands, weighed against (2) the probable gain-risk status of the patient’s treatment choice.

have her sprained wrist bandaged, but not whether to undergo open heart surgery. However, there is a conceptual problem with this type of strategy. It conflates level of competence to decide with level of risk of outcome, when there is nothing to suggest that risky decisions require more ability at decision-making than non-risky ones. It confuses the process with the end result.

Beauchamp and Childress permit the protective agenda without the conceptual sacrifice by instead suggesting that the level of *evidence* for determining competence should vary according to risk, while the competence itself varies only along a scale of difficulty in decision-making. This is a distinction which the court is adept at making, as it did in *Re H (Minors)(Sexual Abuse: Standard of Proof)*¹¹⁹ when the majority of the House of Lords accepted Lord Nicholls' suggestion that in child protection cases, the burden of proof remains the lower civil one; it is just that the more serious the allegation the greater the evidential burden in establishing it.

However the margins are determined, allowing that some groups fall outside the principle of autonomy requires that an alternative decision-making authority be recognised. If integrity of approach is to be preserved, the model for surrogate decision-making must be as close to the autonomy model as possible. Beauchamp & Childress therefore propose surrogate decision-making by aptitude.¹²⁰ The ability to make reasoned judgments (ie competency), and adequate knowledge and information are uncontroversial. Emotional stability is arguably a feature of competency. The "commitment to the incompetent patient's interests that is free of conflicts of interest and free of controlling influence by those who may not act in the patient's best interests" is more debateable. It is a requirement for partiality in favour of the patient, and expressly excludes consideration of the interests of all affected parties.

¹¹⁹ [1996] AC 563. Lord Lloyd dissented, and Lord Nicholls' dicta were not mentioned in the later case of *Re M and R (Child Abuse: Evidence)* [1996] 2 FLR 195, but in *Re U (A Child)(Serious Injury: Standard of Proof)* [2004] 2 FCR 257 the Court of Appeal confirmed them as correctly stating current law.

¹²⁰ *Principles*, p 154

Beauchamp and Childress' primary presumption is that the family is the surrogate authority. There are practical reasons for this: the family is assumed to know and care about the patient more than anyone else. It is also claimed to be a recognition of the family's "traditional role in society."¹²¹ If it is, then a very narrow view of the family is taken. The best interests of the family as a collective, or of other individuals within the family, are ruled out of consideration by the requirement of partiality on behalf of the patient. Moreover the presumption in favour of the family is easily displaced: if they fail to meet the aptitude criteria Beauchamp & Childress urge that recourse must be had to the cool reasoning of strangers – in preference order, healthcare professionals, institutional committees and courts.

Whoever the surrogate, there must be a standard against which they make decisions. Substituted judgment is closer to the autonomy ideal, because it requires the surrogate to make the decision the patient would have made if she could, but there is a practical difficulty in knowing what the patient would have chosen. If there is an advance directive, there is no need for surrogate decision-making; without one, the surrogate is dependent on having a deep understanding of the patient's own beliefs and values, and how they change over time. This is clearly impossible where the patient has never had autonomy, and susceptible to misinterpretation elsewhere. If the surrogate can really answer "what would the *patient* want?" then substituted judgment is acceptable.¹²² If she can only answer "what would I want for her?" then all connection with autonomy is extinguished and the standard is inappropriate.

Beauchamp and Childress take instead the "best interests" test, which requires the surrogate to "determine the highest benefit among the available options, assigning different weights to interest the patient has in each option, and discounting or subtracting inherent risks or costs". It is undoubtedly a demanding task, but again it is limited in the sense that it permits consideration only of the

¹²¹ *Principles* p156. Beauchamp and Childress are almost eager to continue with the comment that "the patient's closest family members are demonstrably unsatisfactory in some cases, and the authority of the family is not final or ultimate."

¹²² This "economy of standards" essentially sees pure autonomy and acceptable substituted judgment as one and the same. They are both justified by the same principle.

patient's interests. Only *indirectly* can the wider context inform the decision. A patient's interests may not be best served by making a medical decision which so exhausts the family that they are driven to withdraw support altogether, but that is a different judgment to one which includes consideration of the family's overlapping interests *on their own merits*.¹²³

The best interests test brings into issue Beauchamp and Childress's third principle. Historically the dominant medical ethic, beneficence aims to promote patients' interests. However, with an inherent assumption of superiority of medical knowledge, it can easily slide into paternalism, which is the antithesis of autonomy. Beauchamp and Childress reconcile the potential conflict with a balancing exercise. Benefit must be placed on a scale with autonomy interests. As a patient's interests in autonomy increase and the benefits for that person decrease, the justification for paternalistic action becomes less cogent; conversely, as the benefits increase and the interests in autonomy decrease, the justification for paternalistic action becomes more plausible. Thus preventing minor harms while deeply disrespecting autonomy is unjustified; but actions that prevent major harms and only minimally disrespect autonomy have a highly plausible rationale.

Annie is not, and never has been, capable of autonomy. Her parents would be the first choice as surrogate decision makers, as long as they have the aptitude, which is called into doubt by the nature of their commitment to Annie and the requirement for impartiality. The imposition on their lives which such severe disability represents must be very great. It is asking a lot of them to consider medical options for Annie without also taking into account the impact of those options on their already compromised lives. Annie's growth and development impact more directly on their lifestyle than hers. There is a conflict of interest here which may disqualify them as surrogate decision-makers. Principlism would then have recourse to institutional committees and courts. Annie and her family

¹²³ See 'Conceptions of family-centred medical decision-making and their difficulties', Insoo Hyun [2003] 12 *Cambridge Quarterly of Healthcare Ethics* 196.

would be dependent on a stranger's view of Annie's 'best interests', individualistically viewed.

Bella is at the margins of autonomy. At fifteen, she has opinions and convictions of her own; but she has little experience of life to inform her understanding of beauty, media manipulation and capitalism. Does she simply have different priorities to her parents, or is she immature, ignorant and exploited? Her decision not to eat has inherent risks of long-term health damage and ultimately death. If it is to be respected, there must be compelling evidence that she can balance her dream of beauty, fame and fortune against the context of distorted media and its physical consequences.

Cecil may feel some constraint on his freedom of decision from his age and physical limitations; and he may not fully understand the ramifications of either hip replacement surgery or the prognosis without it. There will be an obligation on doctors to explain his options in a way that he can understand. If properly discharged, it is likely that Cecil could be rendered sufficiently autonomous to make his own decision; and even if he decides contrary to medical recommendation, the doctors and the daughters must respect his decision.

Annie, Bella and Cecil show us the kinds of issues on which a principlist approach would focus. It is no coincidence that these concerns mirror the issues which, as we shall see, occupy the courts more closely than any of the other philosophical approaches. They do not, however, give us any certainty of outcome, not least because of the subjectivism inherent in assessments of both competence and 'best interests', and the compromise with philosophical coherence which both those concepts represent.

Conclusions

All ethical theories have their defects and their excesses. All of them have a context in which they operate best. In real life, none of them offer simple answers. In our case studies we have seen how different factors seemingly point us to different courses of action, even whilst we view the possibilities through

the same ethical lens.¹²⁴ The debate may be over which benefit is to be maximised, which obligation fulfilled, which virtue exemplified, which relationship enhanced, or which principle applied, but even coherent theories offer only guidance and reasoning, rather than solutions. In the end, they all call for individual judgment on particular facts.

Medical decision making needs an ethic which can be applied at many levels: by the patient themselves, by those who care for her, by the doctors and nurses who treat her, and by the committees and judges who have to determine disputes. It needs to speak across many and diverse issues, from acute to chronic illness, from life to death and all stages in between. It needs to offer guidance where there is doubt, justification where there is dispute, and comfort where there is loss. To meet such demands, it will need to be sensitive, inclusive and fair.

Consequences must play a part. Without some regard to what happens as a result of decisions made, any medical ethic would lack credibility in real life. If people are to be expected to support public policies and live with individual choices, they need to be able to accept their consequences. But acceptance does not imply that the consequence has to be the determining factor in the decision making process. Sometimes it is very difficult to know what would be the *best* outcome: prognoses can be uncertain, even speculative, and progress comes at the price of some degree of experimentation. The impartiality which a consequence-driven ethic demands may be welcomed in the formulation of broad public policy, but overlooks important considerations when issues have to be decided at the individual level.

Obligations offer the security of minimum expectations. Constraints against action protect individuals against majorities, and decision makers against institutional pressure. However, universal rules of obligation rest on fine, but inchoate, notions like rationality and rights. In the particularities of everyday issues, they can often conflict. It is in conflict that we most need guidance, but

¹²⁴ These contradictions are most clearly illustrated by Annie for deontologists, by Bella for utilitarians, and by Cecil for virtue ethicists.

the absolution of obligations offers none. A balancing device is required, but must be found elsewhere.

Virtue is always admirable. There can be no reasonable argument but that virtue is a characteristic to be strived for by our decision-makers. In the hands of virtuous power-holders, there is hope; without it, we are at the mercy of personal whim and ambition. Yet the acquisition of virtue is a personal responsibility, not an enforceable obligation. We can attempt to teach it, but we cannot guarantee or measure our success. At best, we can require our professional decision makers to subscribe to a virtuous code of conduct, regulated by their professional body. Yet even if the decision maker has virtues in abundance, whether she will decide to act upon the same virtue as we would wish her to is only a matter of chance or accidental hegemony. It may be a brave and noble realism for virtue ethics to accept the possibility of dilemma, but accepting that a decision contrary to the one I seek is equally “right”, is often a hard concept to swallow. The subjectivity of choosing between appropriate but competing virtues makes them a weak basis for public policy. Virtue is indispensable as a private ethic, but insufficient for a public one.

Care is a feature of life which most of us recognise. We give it and receive it in different measures throughout our lives. The relationships we are born to and choose for ourselves have a significant impact on all of us, for better and for worse. When medical decisions have to be taken, those caring relationships often assume unforeseen importance: our illness impacts upon those for whom we care, and they have an effect on our prognosis. So there is an attractive realism in an ethical approach which recognises the interconnectedness of life, although in fact the ethic of care is idealised, because it requires us to extend a caring approach even to those who are strangers.

Each of these ethical approaches is self-contained and distinct. In contrast, principlism attempts to choose the best parts of each, and hold them together in a bundle of guidelines to action. It has been successful and influential, but it is vulnerable to the criticism of incoherence, because only parts of theories are espoused. Because it is the strongest parts of theories which are adapted into a

principle, each principle is a powerful guide. When these principles conflict with each other, there is a vigorous collision, with nothing but individual judgment to choose between them. Cherry picking has its downsides.

But different ethical approaches are not always in conflict with each other. It is possible¹²⁵ – maybe even desirable¹²⁶ – that two or more approaches can run in tandem, the one operating to check the excesses or fill the gaps of the other. Dominance of a single theory entrenches weaknesses, and stifles creativity; diversity of approach balances limitations, and fosters ingenuity. Medical treatment disputes are always controversial, often complex, and sometimes at the cutting edge of scientific progress. Ethical guidance needs to be soundly based, but not straitjacketing; maintaining integrity, but open to development.

In the search for an ethical framework by which to evaluate the role of the family in medical treatment disputes, it is important to protect an individual at a time of vulnerability, but also to treat fairly the family which has created and fostered that very individuality. *Combining* ethical approaches offers us the possibility of judgment informed from both perspectives. Thus, we may espouse **obligations** as a minimum standard below which we ought not to fall, ensuring that all patients are valued for themselves; *and* an ethic of **care**, as the ideal, ensuring that sympathetic understanding is brought to bear on the full circumstances of their case. What we are looking for is “individual autonomy in the context of collectivity.”¹²⁷

There is of course inherent and inescapable tension between the individual and the collective focuses of the obligation and care approaches. They are both crucial, but they are not fully compatible. The challenge is not to blend two

¹²⁵ For example Rita Manning thinks that a patient’s rights model and a care model “can often work in tandem and...ought to be so wedded.” : ‘A Care Approach’ in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics* at p103.

¹²⁶ Both Harris (‘In Praise of Unprincipled Ethics’ (2003) *J Med Ethics* 303) and AV Campbell (‘The Virtues & Vices of the Four Principles’ (2003) *J Med Ethics* 292 at 296) criticize the dominance of principlism because of its straitjacketing effect on ethical considerations: “We need a diversity of approach in these complex human scenarios, and no theory should be seen as dominant.”

¹²⁷ Jennifer Nedelsky ‘Reconceiving Autonomy: Sources, Thoughts and Possibilities’ [1989] *Yale Journal of Law & Feminism* 7 at p19.

opposing focus points into a single picture, but to insist on the tension produced by holding them both in the mind's eye at once. A combined ethic is no more or less likely to offer easy answers than adoption of a single philosophical approach. Rather than despairing the impossibility of reconciliation, we should celebrate the reality this brings to our framework. The tension between individual and collective focuses mirrors perfectly the tension inherent in families whenever medical issues arise. The optimal outcome will be a balance - a compromise - between the interests of the individual patient in need of family support, and the family collective in support of their individual member.

Applying the combined ethical approaches of obligations and care to the fictional case studies demonstrates the balancing that is required. The constraint which protects Annie against surgical intervention without physiological needs is measured against the benefit to her of maintaining family care. The maxim of respecting Bella's personhood, even when it may be self-destructive, is mitigated by a requirement to consider that personhood fully in context. The constraint which allows Cecil to refuse treatment is balanced against an obligation on him to consider the impact of refusal on others. The combined ethical approach does not throw out easy answers, but it lays bare the stakes; and it acknowledges a place for judgment.

Selecting a combination of just two ethical approaches for the legal framework in which to determine medical treatment disputes does not mean that we reject the others. We all hope for virtuous doctors, judges and even families; but regulation of their virtue is more practically left to their professional bodies and their consciences than imported into decision-making frameworks. Similarly, whilst consequences are of course that part of decision-making with which we all have to live, if the method and the content of the decision-making process is right and fair to all affected, it follows that the outcome should be acceptable to us, even if we do not agree with it. Formulating our ethical framework without direct reference to virtue and consequence does not mean that either is abandoned.

The role we ascribe to families in the determination of medical treatment disputes is a question which affects countless people every day. We all need an

approach that values patients, surely, but also the context in which their existence is made possible. Nothing less should be expected of those who assume responsibility for our health and wellbeing, and ultimately our lives. An ethical approach which combines deontological constraint as a minimum standard and care as an ideal offers the best prospect of optimal outcome. It is the benchmark by which I shall assess the role which the courts allow the family in medical decision making, and against which I shall measure my conclusions.

Chapter 3

Medical Treatment Disputes: The Legal Jurisdiction

This chapter examines the historical development of the courts' common law jurisdiction to determine disputes about medical treatment.

Competent adults hold a determinative power to give or withhold consent to treatment, but persons lacking capacity to decide for themselves require a different legal approach. In respect of children, the ancient parens patriae jurisdiction continues alongside modern statutory provision, giving the courts wide powers to determine issues according to the child's best interests. In respect of incompetent adults, the incidental death of parens patriae left the courts with no equivalent jurisdiction. Perceiving this as a dangerous failure of society to protect its most vulnerable members, whilst calling for statutory intervention the courts developed a declaratory procedure under inherent jurisdiction.

The extent and merits of the declaratory procedure are considered, and the role implicitly ascribed to the family identified, with a view to informing assessment (in later chapters) of the statutory intervention which ultimately superseded it.

Medicine, like any other social activity in an open and democratic society, is subject to the rule of law. It is an axiom of English law that any intentional touching of the person without consent amounts to trespass and battery, which is answerable in both criminal prosecution and civil suit.

However, in the ordinary course of life, complete freedom from physical contact by others is unattainable. Every time we get on a crowded commuter train we are subject to jostles and pokes, but we accept them simply as the unpleasant side-effects of participating in an over-crowded world. If it were possible to prosecute or sue for each jostle and poke, we would all soon drown in litigation. Accordingly, exceptions to the general principle of physical inviolability have developed, and the reasonable exigencies of everyday life is one of them.¹ It can be rationalised as derived from implicit consent, inherent in the very act of participating in society, but from the first judicial exposition,² such rationalisation has been rejected as artificial. It is generally accepted, as the case of *Wilson v. Pringle*³ demonstrates, simply that the general rule is subject to an exception “embracing all physical contact generally acceptable in the ordinary conduct of everyday life.”⁴

Medical treatment is not part of the ordinary conduct of everyday life.⁵ Illness is regarded as an aberration from the norm, not something that we willingly accept, but something of which we would like to be cured. Therefore, insofar as medical treatment involves interference with physical integrity – which most of it does – if it is to be lawful, *prima facie* it must be done with consent.⁶

¹ Recognised as long ago as the seventeenth century in *Tuberville v. Savage* (1669) 1 Mod 3

² By Goff LJ in *Collins v. Wilcock* [1984] 1 WLR 1172 at 1177, by which time the general exception was long-established and widely accepted. When giving this exposition, Goff LJ could not have known that it would later feature significantly in the seminal case of *Re F* [1990] 2 AC 1, in which he also gave the leading judgment.

³ [1987] QB 237

⁴ Goff LJ in *Collins v. Wilcock* [1984] 1 WLR 1172 at 1177.

⁵ Croome-Johnson LJ in *Wilson v. Pringle* [1987] QB 237 at p252 apparently suggests that even ‘a casualty surgeon...perform[ing] an urgent operation on an unconscious patient who is brought to hospital’ can be seen as a feature of everyday life, and therefore within the exception to the general principle. However his comment was obiter and unreasoned. It should not be considered a good statement of the law. Lord Donaldson in *Re F* [1990] AC 1 at p16 specifically denies that such physical intervention comes within an exception of ‘vicissitudes of everyday life’- which is why he is forced to find another basis for decision in the seminal case (see below).

⁶ “In the absence of consent all, or almost all, medical treatment and all surgical treatment of an adult is unlawful, however beneficial such treatment might be. This is incontestable.”: per Lord Donaldson in *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 at p11. (On the other hand, consent alone is not *sufficient* to make surgery lawful. It was established in *R v. Brown* [1993] 2 All ER 75 that consent is not a defence to criminal charges of causing actual or grievous bodily harm. The cutting involved in surgery would *prima facie* amount to actual or grievous harm. It is generally accepted that *reasonable* surgery is in a category of exceptions which ‘stand outside criminal law’.)

Medical expertise is hard won: doctors study for many years, and have to pass many exams before they are qualified to treat patients. Patients, on the other hand, become ill or disabled merely at the whim of fortune. It is easy to see the temptation to fall into an attitude of ‘doctor knows best’. The axiom of law operates to block any such approach to treatment. In the medical context, the principle of physical integrity and the need for consent to any interference with it means that doctors must have the permission of the competent patient before they embark upon any medical examination or course of treatment, no matter how obviously beneficial it would be to the patient’s physical well-being. The patient may *refuse* her consent, for any reason, wise or foolish, or indeed for no reason at all, and however deleterious the consequences to her health.⁷ The doctor is bound by such refusal; and any treatment in disregard of it leaves the physician vulnerable to prosecution and civil action.⁸

The principle behind the requirement for consent to any interference with physical integrity is the liberal and laudable one of protecting individual freedom. However, where a patient is *not capable* of giving consent, by reason of illness or disability, strict application of the principle could, particularly in the medical context, have quite the opposite effect. Infringements of their physical integrity which would be beneficial to them, would be denied to them. Yet no one would want to see an Alzheimer’s patient deprived of treatment for her leg ulcers because she could not give valid consent to the nurse touching her. It would offend our civilised sense of a basic duty to protect the most vulnerable members of society. In such circumstances, fear of personal liability on the part of a treating physician should not be a barrier to care. So, the general principle of physical inviolability requires modification where the capacity to consent is lacking.

⁷ *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871. “The right to refuse exists even where there are overwhelming medical reasons in favour of the treatment and probably even where if the treatment is not carried out the patient’s life will be at risk.”: per Neill LJ in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at p29.

⁸ The classic expression of this is Cardozo J’s in *Schloendorff v. Society of New York Hospital* 105 NE 92 (NY, 1914): “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient’s consent commits an assault.” The leading English authority of the same principle is *A-G’s Reference (No. 6 of 1980)* [1981] QB 715.

The law has always recognised two distinct branches of incapacity. *Minors* are deemed to lack capacity unless the contrary is shown, by the unarguable fact of their age.⁹ The assumption is that they will acquire capacity in due course, simply by growing up, but until then they are denied capacity by operation of law. In contrast, *adults* are assumed to be competent unless the contrary is shown; and adult incapacity may be permanent or fleeting. Adults may never have acquired competence, or they may lose what they once had; they may lose it permanently, or it may later be restored.

Having conceived of incompetence in these two distinct branches, development of the law modifying the requirement for consent to medical treatment has also followed different lines for children and adults:

Jurisdiction in respect of children

A new born baby is capable of very little, and certainly not of deciding whether or not to allow medical intervention. It is therefore obvious and right that, amongst the bundle of parental rights and responsibilities which the law gives to parents¹⁰ from the moment of birth, is the ability to give a valid consent to medical treatment of the child.

(As the child grows and matures, the obviousness and rightness of this becomes less clear. By the time a child reaches 16 years old there is statutory recognition of her ability to consent,¹¹ and she may have developed capacity at common law before then. The interesting legal issue here however is not one of jurisdiction but of capacity, which will be considered in chapter four. For the purposes of

⁹ The legal age of majority is 18, but pursuant to section 8 of the Family Law Reform Act 1969, the age of legal capacity to give a valid consent to medical treatment is 16. Minors may be credited with capacity to consent to treatment before that age IF they satisfy their doctor of appropriate understanding: see *Gillick v. West Norfolk & Wisbech AHA [1986] AC 112* and chapter 4 below.

¹⁰ For these purpose, unmarried fathers are included only if they jointly registered the birth of a child after 1st December 2003, or else hold a parental responsibility agreement or order.

¹¹ Family Law Act 1969 s8

examining jurisdiction, it is apposite to focus on the relatively simple situation of a young child, clearly dependent on others in matters of judgment.)

In most everyday situations, if a parent gives consent for their child to receive medical treatment, the legal considerations are satisfied, the physician is confident of her ability to act, and the treatment is given. Equally if the parents refuse to consent, the treatment cannot be given and that is the end of the matter. There is no requirement that, in either giving or refusing consent, the parents make what would generally be regarded as the correct decision.¹² Hence, where parents agree that their child should not receive the standard childhood inoculations which the medical establishment considers appropriate,¹³ or where parents agree that their son should undergo the surgically intrusive and painful procedure of circumcision, without medical justification but for cultural reasons,¹⁴ their decisions are lawful.

It is only where there happens to be disagreement between the parents and someone else involved in the care of the child (most often, but not always, the medics themselves) that the right of the parents to decide whether or not to allow medical treatment comes under scrutiny. At that point, it is possible to invoke the jurisdiction of the court to determine the dispute. The only question is, how?

As a matter of ancient legal history the Crown, as father of the nation, had the prerogative of caring for those of its subjects who could not look after themselves: the doctrine of *parens patriae*. It was most regularly exercised in the context of orphaned young nobles, allowing the monarch to control the handling of their valuable estates. In time, this jurisdiction was delegated, first to the Court of Chancery and thence to the Family Division, and became exercisable as “inherent jurisdiction” (although such a phrase was not in common use until the Children Act debate of the 1980s). It is a concept similar to the rules of equity,

¹² As long as they are within a range of reasonableness, as the reference to ‘most everyday situations’ implies. Parental pursuit of medically inappropriate treatments, or parental failures to pursue medical necessities, may both fall foul of criminal law and incur civil law interventions, such as applications for care or supervision orders.

¹³ See *Re C (Child)(Immunisation: Parental Rights)* [2003] 2 FLR 1054 and chapter 4 hereafter.

¹⁴ See *Re J (Specific Issue Orders: Child’s religious upbringing and circumcision)* [2000] 1 FLR 571 at 689 and chapter 4 hereafter.

enabling whatever is *right* to be done, even in the absence of statutory powers; and it is in theory unlimited.¹⁵

In respect of minors, the inherent jurisdiction was mostly exercised by making the child a ward of court. There had been some acknowledgment of a wider *parens patriae* power¹⁶ but it was undeveloped because of wardship's dominant flexibility. Wardship is a status; and its unique import is that *no* important step can be taken without the court's consent for as long as the wardship continues, thereby affording a very high degree of protection for the child. Moreover it has procedural features which make it very attractive to litigants: the case is handled by a senior judge, and the determination is dictated not by any rigid criteria, but simply by reference to the child's best interests. Consequently, the range of possible orders is theoretically limitless, and each determination can be as individual as the child's own fingerprints. Such scope and flexibility ensured for wardship powerful popularity and support in the legal establishment.

By comparison, the range of statutory jurisdictions historically available in respect of children was chaotic, incoherent and widely deplored by those who operated and depended on it. Inevitably, legal practitioners therefore bypassed the statutory jurisdiction wherever possible, and the wardship procedure became overused, particularly by Local Authorities,¹⁷ putting great strain on court resources. A practical need to rationalise the court's jurisdiction in relation to children built up, and it culminated in the passing of the Children Act 1989.

The Children Act 1989 provides the courts with statutory authority to make a range of orders in respect of children, including the power to determine a 'specific question which has arisen, or which may arise, in connection with any

¹⁵ As Lord Donaldson noted in *Re W (A Minor)(Medical Treatment: Court's Jurisdiction)* [1992] 4 All ER 627 at 637. (Although in reality the courts accept that the jurisdiction may not be used so as to compel a doctor to act contrary to his clinical judgment.)

¹⁶ For example, *Re N (Infants)* [1967] Ch 512, and *Re L (An Infant)* [1968] P119 CA.

¹⁷ By 1989 62% of cases involved the Local Authority, compared to just 3% in 1971.

aspect of parental responsibility for a child'.¹⁸ In resolving such a question, the court is to have the child's *welfare* as its paramount consideration.¹⁹

The Children Act was initially intended to be a comprehensive codification of court powers, such as would leave no room for inherent jurisdiction. In their early working paper "Wards of Court",²⁰ No. 101 1987, the Law Commission canvassed abolishing the wardship jurisdiction altogether. However in their final report, "Guardianship and Custody Guardianship",²¹ substantive recommendations for reform of wardship were expressly postponed, on the grounds that not every contingency may have been foreseen, and its retention would cater for exceptional cases which would otherwise slip through the statutory net.²²

As the debate progressed, in the light of the Law Commission's stance, and keen to limit extra-statutory recourse to courts, Government lawyers drafting the Act emphasised anew the almost forgotten fact that wardship was simply a part (albeit a large one) of the ancient non-statutory (ie inherent) jurisdiction.²³ The corollary of this was that a child could be the subject of High Court intervention without actually being made a ward of court. Single issue court determinations, without wardship's element of continuing supervisory function, were thereby endorsed.

This interpretation of inherent jurisdiction neatly met the government's twin objectives of reducing the court burden, and not offending Law Commission recommendations. It suited the courts too, for they have been able to keep their

¹⁸ Children Act 1989 s 8(1)

¹⁹ Children Act 1989 s1(1)

²⁰ 1987, no. 101

²¹ 1988, no. 172 at para 14

²² It is easy to infer that this cautionary approach was inspired by the experience of abolishing *parens patriae* in respect of adults (see discussion, at pp8-10 below). *Re F (Mental Patient: Sterilisation)* 2AC 1 and the cases leading up to it, which revealed significant problems in the wake of abolition of *parens patriae* for adults, were going through the courts at the same times as these consultations were being aired.

²³ "In the government view wardship is only one use of the High Court's inherent *parens patriae* jurisdiction. We believe, therefore, that it is open to the High Court to make orders under its *inherent jurisdiction* in respect of children other than through wardship.", Lord Mackay LC, Joseph Jackson Memorial Lecture (1989) 139 NLJ 505 at 507 (*italics added*). And a new phrase was born!

jurisdiction cake and eat it. With no statutory limitation of access to the inherent jurisdiction in private law proceedings, the courts are able to respect the underlying notion of wardship as a fallback device,²⁴ and still determine appropriate cases simply according to the best interests of the child.

Firmer statutory control was deemed necessary, however, for the Local Authorities who had previously most overused non-statutory power. On the Government's own initiative and without widespread consultation,²⁵ section 100 was inserted into the draft statute, providing that wherever a statutory procedure is available, the Local Authority must use it. The Authority may only be granted leave to invoke inherent jurisdiction where there is reasonable cause to believe that, without it, a child is likely to suffer significant harm.²⁶

Limitation is, however, crucially short of exclusion, and the courts have shown themselves willing to capitalize on the distinction wherever necessary. In *South Glamorgan CC v. W & B*²⁷ Douglas Brown J robustly asserted that "in an appropriate case, when other remedies of the Children Act have been used and exhausted and found not to bring about the desired result, [the court] can resort to other remedies..."²⁸ Section 100 may have closed the door to the Local

²⁴ Per Waite LJ in *Re T* [1994] Fam 49 at p60: "The court's undoubted discretion to allow wardship proceedings to go forward in a suitable case is subject to their clear duty, in loyalty to the scheme and purpose of the Children Act legislation, to permit recourse to wardship only when it becomes apparent to the judge in any particular case that the question which the court is determining in regard to the minor's upbringing or property cannot be resolved under the statutory procedures in Part II of the Act in a way which secures the best interests of the child; or when the minor's person is in a state of jeopardy from which he can only be protected by giving him the status of a ward of court; or where the court's functions need to be secured from the effects, potentially injurious to the child, or external influences (intrusive publicity for example) and it is decided that conferring on the child the status of a ward will prove more effective deterrent than the ordinary sanctions of contempt of court which already protect all family proceedings."

²⁵ See Lord Mackay's Joseph Jackson Memorial Lecture (1989) 139 NLJ 505.

²⁶ S100(4)

²⁷ [1993] 1 FLR 574: A fifteen year old girl was beyond parental control and had barricaded herself into her bedroom for the last eleven months. Protracted proceedings under the Children Act culminated in an interim care order and directions under s38(6) that the child receive psychiatric assessment and, if necessary, treatment at an adolescent unit. The court gave the Local Authority permission under s100(3) to invoke the inherent jurisdiction if the teenager refused the necessary consent. She did refuse, and the Local Authority did invoke the inherent jurisdiction, effectively asking for judicial approval of assessment and treatment. The court exercised its inherent jurisdiction as the LA asked.

²⁸ At p584.

Authority's access to the inherent jurisdiction, but the courts have shown themselves willing to open it.

So, the combined effect of the Children Act and the court's inherent jurisdiction is that when, by chance, others involved in the medical care of a child disagree with the parents' treatment decision, the dispute can be put to a judge.

Once the issue is referred to a court, the judge assumes decisive power. If the matter is determined under the statutory jurisdiction, the court must have regard to the child's own wishes and feelings,²⁹ but is under no compulsion to regard the parents' wishes and feelings. The only requirement in respect of the parents is to consider how capable each of them is of meeting the child's perceived needs.³⁰ If the matter is determined under the inherent jurisdiction, "the decision ... lies with the court";³¹ and the sole criteria for the deciding is the best interest of the child.

Whatever the legal basis for court authority, the court's assessment is sovereign. Judicial assessment is emphatically *not* a test of parental reasonableness.³² The views of the parents simply inform the court's decision, in the same way as do the views of other parties to the case:

"When it comes to an assessment of the demands of the child's welfare, the starting point – and the finishing point too – must always be the judge's own independent assessment of the balance of advantage and disadvantage of the particular medical step under consideration."³³

So, when capacity is lacking due to simple minority, the general principle of physical inviolability is modified in two distinct ways. *Prima facie*, the power to

²⁹ Considered in the light of his age and understanding: Children Act 1989 s1(3)(a).

³⁰ Children Act 1989 s(3)(f).

³¹ Per Templeman LJ in *Re B (A Minor)(Wardship: Medical Treatment)* [1981] 1 WLR 1421.

³² Parents can be caring and reasonable but still 'wrong': see *Re B* [1981] 1 WLR 1421 and chapter 4.

³³ Per Waite LJ in *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906 at 254.

consent is simply shifted wholesale to parents. However, if others disagree with the parental position, Parliament and the courts have modified the principle instead to allow *judges* to determine what is in the minor's best interest, and then grant or withhold authority to medical treatment accordingly. As soon as court jurisdiction is invoked, the family role is reduced to merely providing information – and living with the consequences of the judicial decision.

The twin modifications of the general principle of physical integrity in respect of children echo both the practicality of the approach to 'everyday exigencies' and the historical origins of the inherent jurisdiction, reflecting at once both questionable complacency and excessive suspicion. For the most part, parents will be left free to pursue the life pattern they choose for their children. However, if a third party objects sufficiently to take the matter to court, parental authority is not simply questioned, but totally removed. As soon as court jurisdiction is invoked, state authorities assume a right of determination, just as if the minors in question today are as bereft of parental influence as were the minors when *parens patriae* was first delegated.

Jurisdiction in respect of Adults

Historically, the *parens patriae* jurisdiction in respect of adults followed a different course. Following the Restoration, the Crown's power in relation to "lunatics" was assigned by letters patent under the Great Seal, and latterly by warrant under the Sign Manual, to specific individuals rather than to a court. Initially the Lord Chancellor held the power; then from 1851, the Lord Chancellor and the Lords Justices of Appeal; and finally by warrant dated 10th April 1956 the Lord Chancellor and the judges for the time being of the Chancery Division (who also exercised statutory jurisdiction under the Lunacy Acts of 1852-1890).

However, when the statutory provisions were updated, the combined effect of s1 of the Mental Health Act 1959 and a Warrant of Revocation under the Sign

Manual (dated 1st November 1960) was to revoke the 1956 warrant,³⁴ and thereby end the *parens patriae* jurisdiction in respect of adults. A reading of the Warrant of Revocation makes plain “that such jurisdiction as the High Court previously had was extinguished...”.³⁵

Why should such a useful jurisdiction, exercised for the benefit of those who are most vulnerable, be removed? Much later, Lord Goff was driven to say that he had “never heard a rational, or indeed any, explanation for this step.”³⁶ It seems likely that it was simply a matter of procedural zealotry in the passing of the new legislation, as the intention behind the Mental Health Act 1959 was codification of the law.³⁷ After declaring the extinction of the previous High Court jurisdiction, the Warrant of Revocation continues: “...it being envisaged that the situation would thereafter be governed by the Mental Health Act 1959”.³⁸

The new Act created statutory guardianship, which gave a Guardian the same powers as a father would have in respect of a child under the age of 14³⁹ - and therefore provided for consent to medical treatment. So for a while, there was no difficulty: cases were simply resolved by the appointment of a statutory guardian.

However, during the late 1970s and early 1980s it became government policy to reduce the role of the state in the lives of the mentally incapacitated, and the mental health legislation was reformed to reflect that policy. In particular, the scope of guardianship was drastically reduced by the Mental Health

³⁴ With effect from 1st November 1960, when the new act came into force.

³⁵ Per Scott-Baker J in *Re F (Mental Patient: Sterilisation)* at first instance (unreported, but transcribed. A copy of the transcription is held in the judicial papers collection of Lincoln’s Inn library).

³⁶ *Airedale NHS Trust v. Bland* [1993] 2 WLR 316 at p875.

³⁷ “The care and commitment of the custody of the persons and estate of mentally disordered persons, which belong to the Crown at common law from very early times, and was invariably delegated to the Lord Chancellor by warrant under the sign manual, *is now entirely governed by statute.*” (italics added), Halsbury’s Laws of England vol.8 p588, as quoted by Lord Hailsham in *Re B (A Minor)(Wardship: Sterilisation)* [1987] 2 WLR 1213.

³⁸ Continuing the quotation from Scott-Baker J in footnote 35 above.

³⁹ S34(1) Mental Health Act 1959 and reg 6(2) Mental Health (Hospital and Guardianship) Regulations 1960

(Amendments) Act 1982, the relevant provisions of which were subsequently carried over into the Mental Health Act 1983.

One result of these amendments was that a much narrower group of mentally incapacitated people fell within the criteria of guardianship, because the mental impairment now had to be associated with abnormally aggressive or seriously irresponsible conduct. And in addition, the powers of the Guardian were curtailed: the Guardian could now only require the patient to live at a specified place, or to attend specified places for treatment, and ensure that a doctor, social worker or other specified person could see the patient at home. Crucially, this curtailment *excluded* the power to give consent to medical treatment.

So there arose a gap in the law.⁴⁰ Nobody had the power to give consent to the medical treatment of patients unable to decide the matter for themselves. Not unreasonably, doctors became very concerned for their own position. Should anybody choose to challenge their treatment of a mentally incapacitated patient, criminal prosecution or civil suit was a very real possibility. Where the proposed treatment was in any way controversial, such as abortion or sterilisation, doctors became unwilling to operate without the prior protection of the court.

The difficulty for the court was how to provide that protection, and thereby enable the patient to be treated. In this context, another of the modifications to the general principle of inviolability requires consideration.

The defence of ‘necessity’: Leading reference books on the law of Torts⁴¹ relate that there is a recognised defence to accusations of touching without consent, namely ‘necessity’. The test of the defence is said to be that the act in question is “reasonably necessary to prevent harm”,⁴² which is generally understood to

⁴⁰ In May 1989, “the startling fact” was “that there is no English authority on the question whether as a matter of common law (and if so in what circumstances) medical treatment can lawfully be given to a person who is disabled by mental incapacity from consenting to it.” Per Lord Goff in *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

⁴¹ For example, Clerk & Lindsell on Torts in chapters 3 (particularly 3-114 and following) and 15. Markesinis & Deakin’s Tort Law asserts unequivocally at p458 that “it is well-established that necessity may be a defence in the context of an emergency that compels a rescuer to act”.

⁴² Clerk & Lindsell on Torts at 3-116.

mean that actions covered by this exception are limited to those which are necessary to meet the emergency.⁴³

The principle behind the defence of necessity remains “somewhat vague.”⁴⁴ Certainly there is judicial authority which justifies trespass to *property* by the necessity of saving life;⁴⁵ but it is less clear that preventing harm – even preventing death – justifies violating the physical integrity of persons. On the contrary, it is certain that such necessity cannot override either a competent person’s refusal to consent to violation of their physical integrity,⁴⁶ or the competent prior refusal of a now incompetent person.⁴⁷

Notwithstanding the vagueness of the defence, ‘necessity’ of some sort has become central to the justification of violations of physical integrity of persons for whom giving consent is impossible because of incapacity.

The First Attempt to Find a Jurisdiction: There were three cases which tackled the problem of medical reluctance to treat incompetent adult patients at first instance before it reached the authoritative consideration of the appeal courts. *Re T* was decided by Latey J on 14th May 1987. The decision was not reported or transcribed, and the tapes have now been destroyed, so analysis of the decision is not possible. Quickly afterwards, the decision of Reeve J in the case of *Re X*⁴⁸ was briefly reported in the Times newspaper on 4th June 1987. And then the case of *T v. T*⁴⁹ was decided by Wood J. On each occasion the court made a declaration under Order 15, Rule 16 of the Rules of the Supreme Court, that the proposed treatment would be in the patient’s best interests and therefore not unlawful.

⁴³ As repeated by Neill LJ in *Re F*. [1990] AC 1 at p30.

⁴⁴ Clerk & Lindsell on Torts at 3-114. For instance, there is no citation of any clear authority before *Re F* in which ‘necessity’ formed the *ratio decidendi*.

⁴⁵ *Southport Corporation v. Esso Petroleum Company* [1954] 2 QB 182, Devlin J.

⁴⁶ *Re B (Adult: Refusal of Treatment)* [2002] 2 FCR 1. See chapter 4.

⁴⁷ Mental Capacity Act 2005 ss24-26. See chapter 6.

⁴⁸ X was an adult with Down’s Syndrome, who became pregnant. The medical intervention in question was abortion. The application to court was brought by X’s carer.

⁴⁹ [1988] Fam 52. T was a severely mentally handicapped woman of 19, found to be pregnant. Her mother sought declarations in respect of abortion and sterilisation.

The problem with this approach is that Order 15 Rule 16 is a rule of procedure, not a source of jurisdiction. It simply provides that:

“No action or other proceedings shall be open to objection on the ground that a merely declaratory judgment or order is sought thereby, and the court may make binding declarations of right whether or not any consequential relief is or could be claimed.”

This rule allows courts to entertain proceedings for a declaration of rights without an associated claim for rectification or damages; it does not itself create any rights.

The judges in *Re T*, *Re X* and *T v. T* therefore had to find a legal basis – “any basis”⁵⁰ - on which to rest the procedure. Wood J considered three. He rejected the notion of implied consent as “wholly unrealistic”⁵¹ to a situation where a patient has never had capacity. He found “necessity” too imprecise a test of what a court would consider justification for the operative procedures in question. He asked instead *what medical practice demanded*, expressly limiting himself to non-contentious situations.⁵²

The answer Wood J found to his question was that a decision should be reached *in the best interests of the patient*. Examining the scope of, and exceptions to, the tort of trespass, he felt constrained by authority to conclude that such treatment would be “hostile” as the word applied to the tort of trespass, but able to say it would be *justified*. In effect, he invented a new exception to the principle of inviolability, based upon best medical practice in the exceptional circumstances where there is no provision in law for consent to be given.

These three cases are examples of courts “making it up as they go along” in order to meet a very real need. Filling-in gaps is a long tradition of the common

⁵⁰ As Wood J described it at p62. The search was desperate!

⁵¹ p67

⁵² At p63, “I use the word ‘demand’ because I envisage a situation where based upon good medical practice there are really no two views of what course is for the best.”

law,⁵³ but everybody concerned must have realised that the validity of the declarations was highly questionable. If they did, it did not matter only because the declarations served their purpose: they had a court seal, however novel the jurisprudence, and that gave the physicians sufficient confidence to carry out the procedures in question. Nobody challenged it because everybody (or at least everybody who was capable of forming a judgment) wanted the same thing.

The Seminal Case: The next case was different, because it did not quite fall within Wood J's non-contentious view of medical demand. The case was *Re F (Mental Patient: Sterilisation)*.⁵⁴

A 36 year old mentally handicapped woman formed a sexual relationship with a fellow resident at her mental hospital. An application was made to the court⁵⁵ for a declaration that it would be lawful for F to be sterilised notwithstanding that she was incapable of consenting to the operation. There was general medical agreement that a pregnancy would have catastrophic consequences on F's psychiatric wellbeing, and that less draconian forms of contraception were impracticable. However, the Official Solicitor appeared as *amicus curiae*, and he relied on the evidence of an independent medical expert, one Dr. Campbell, who preferred to protect F from the risks of pregnancy by terminating sexual contact rather than imposing surgery.

Scott Baker J found as a fact that terminating all sexual contact in the future would require serious restrictions of F's freedom, with extremely detrimental

⁵³ Per Lord Scarman in *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] A.C. 871 at p884: "This remains the approach of the judges to new or as yet unconsidered situations. Unless statute has intervened to restrict the range of judge-made law, the common law enables the judges, when faced with a situation where a right recognised by law is not adequately protected, either to extend existing principles to cover the situation or to apply an existing remedy to redress the injustice. There is here no novelty: but merely the application of the principle *ubi jus ibi remedium*."

⁵⁴ [1990] 2 AC 1

⁵⁵ The proceedings were issued in the name of F, rather than her mother, because F was eligible for Legal Aid and her mother was not (see Lord Donaldson at p8). This affected the procedure, but not the substantive decision, of the proceedings.

effect. His conclusions as to the law then followed the reasoning of Wood J in *T v. T*, to which he had been referred. He declared pursuant to Order 15 Rule 16 that sterilisation was in F's best interests, and therefore a medical adviser acting in good faith would be justified in law in performing the operation.

The Official Solicitor did not agree.⁵⁶ It is his job to safeguard the interest of those who are incapable by reason of mental disorder of managing their own affairs; and he sought leave to intervene and to appeal. His argument, as framed by James Munby QC,⁵⁷ was that the declaratory powers of RSC Ord 15 r16 permitted only declarations of rights or interests recognised in law; and that what had in fact been declared was merely an absence of right (to sue) in the event of future act by the health authority (performing an operation without consent), involving the court in the forbidden territory of advisory opinion.

Before the Court of Appeal, lawyers for all parties agreed that *parens patriae* jurisdiction was no longer available to solve the problem. The Court of Appeal was therefore deprived of the opportunity to consider the point directly.⁵⁸ The House of Lords refused to be so deprived and positively requested that the Official Solicitor advance such arguments as could be advanced that the jurisdiction had *not* been abolished.⁵⁹ James Munby QC rose to the challenge "with great ability", but nonetheless their Lordships "came reluctantly to the conclusion"⁶⁰ that "the concessions made below...were rightly made."⁶¹ Their Lordships had tried hard to retain *parens patriae*, but had to admit defeat.

⁵⁶ His disagreement was what distinguishes *Re F* from the three cases which went before it, and what explains why *Re F* went on to higher judicial consideration. It was based on the expert report of Dr. Campbell.

⁵⁷ Who did not appear below. At first instance, the Official Solicitor had been represented by junior Counsel, Alan Levy, who continued in his role as *amicus curiae*. The complexities of the parties and representation in this case were an incidental reflection of the fact that the initial application had been brought by F herself, for reasons of legal funding (see footnote 55).

⁵⁸ Neill LJ however offered a preliminary view that "the power remains though it is dormant and incapable at present of being exercised. It seems to me that it would require clear statutory words to remove from the Crown a prerogative power which has vested in the Crown since at least 1325." [1990] 2 AC p26

⁵⁹ As was later recounted by Lord Goff in *Airedale NHS Trust v. Bland* [1993] 2 WLR 316 at 862.

⁶⁰ Lord Goff in *Airedale NHS Trust v. Bland* [1993] 2 WLR 316 at 862

⁶¹ Per Lord Goff, at p 71; Lord Brandon at p58; and Lords Bridge, Griffiths and Jauncey in their agreement with their conclusions.

The loss of the jurisdiction caused “dismay”.⁶² The instinctive reaction of the Court of Appeal was to search for another way of achieving the same ends.⁶³

Lord Donaldson makes clear in the opening paragraphs of his judgment that he sees the practical issues around treatment of children and incompetent adults as analogous,⁶⁴ a clear hint of the interpretation of law to come. He qualifies the requirement for consent, both by context and by exceptions. The context is co-existence with a baldly stated, unreasoned ‘right to skilled treatment’;⁶⁵ the exceptions are ‘emergency medical treatment’ and ‘vicissitudes of everyday life’.

Of the two exceptions, the former is the defence of necessity,⁶⁶ and the latter is expressly said to exclude medical treatment,⁶⁷ but Lord Donaldson finds a common thread between them in a “general rubric of ‘generally acceptable standards’.”⁶⁸ Since even Mr. Munby accepted that *some* forms of treatment of incapacitated adults were generally acceptable, the law in relation to the treatment in issue, namely sterilisation, must depend on the same principle as renders

⁶² Lord Goff in *Airedale NHS Trust v. Bland* [1993] 2 WLR 316 at 862

⁶³ As is hinted by Lord Goff at p863, when considering their objections to the declaratory procedure. Lord Donaldson rationalised it as common law filling the gaps, echoing Lord Scarman in *Sidaway* (see footnote 53): “This process of using the common law to fill gaps is one of the most important duties of judges...It is an essentially judicial process...” per Lord Donaldson at p13.

⁶⁴ At p6-7 “This is the tale of 2 women, F and B. Their circumstances are strikingly similar with one exception. F is aged 36 and B was aged 17.” And at p11: “Put more graphically, but wholly accurately, *Re F* is *Re B* four weeks later, when B would have had a chronological age of 18.” For consideration of *Re B*, see chapter 4.

⁶⁵ p13

⁶⁶ At page 13: “It is well settled that a doctor who is faced with an unconscious patient...is lawfully entitled to carry out such treatment as is *necessary* to safeguard the life and health of that patient, notwithstanding that the patient is in no position to consent or to refuse consent.” (italics added) Lord Donaldson continues with a concession that “the juridical basis of this exception does not appear to have been considered by the English courts until the judgment of Robert Goff in... *Collins v. Wilcock*”.

⁶⁷ At p 16: “I have some difficulty in accepting that...emergency medical treatment of an unconscious patient [was] subsumed under the one umbrella of actions ‘acceptable in the ordinary conduct of everyday life.’” Non-emergency treatment would be even harder to see so subsumed.

⁶⁸ p17. “That is not to say that they are lawful *because* they accord with generally acceptable conduct – only that for this reason it is not surprising that the common law regards them as lawful...”

that more minor treatment lawful. Acknowledging – but rejecting – the possibility that the general acceptance of less serious treatment without consent could be “a case of *communis error facit jus* on the grandest possible scale,”⁶⁹ he notes that “it would not be surprising if the common law rule were subject to a further qualification in relation to those who by reason of disability are unable to consent.” And he then proceeds as if the unsurprising qualification did indeed exist.

Lord Donaldson then found the criteria by which “doctors and others who have a caring responsibility”⁷⁰ should apply this exception by analogy with the guardianship of minors jurisdiction, namely acting in the patient’s best interests⁷¹ - as the opening paragraphs of his judgment had foretold. The only thing distinguishing sterilisation from less invasive treatments is the difficulty involved in discharging the duty. Sterilisation (together with abortion and living organ donation), he said, is in a special category which requires court approval in advance.

Neill LJ looked at circumstances where the defence of consent had clearly failed in law – where two men had inflicted injuries on each other in the course of a fight to which they both agreed⁷² - and concluded that consent gave way to public policy. Public policy, he said, was also the justification for the “well recognised” (but again uncredited) exception of medical emergency; and the determination of what else may offend public policy was a matter for the courts.⁷³

⁶⁹ At p17

⁷⁰ At p18.

⁷¹ At p17: “I see nothing incongruous in doctors and others who have a caring responsibility being required to act in relation to an adult who is incompetent to exercise a right of choice in exactly the same way as would the court or reasonable parents in relation to a child... and I am satisfied that that is what the law does require.”

⁷² AG Ref (No6 of 1980) [1981] QB 715

⁷³ p29

He found no distinction between sterilisation and any other operation of major impact, such as removal of non malignant tumour or hip replacement.⁷⁴ He considered that if any such operation was “*necessary*”, public interest would justify what otherwise would be a trespass. Crucially, he defined ‘necessary’ as meaning “that which the general body of medical opinion in the particular speciality would consider to be in the best interests of the patient in order to maintain the health and secure the wellbeing of the patient.”⁷⁵

Neill LJ envisaged that in the vast majority of cases, those who cared for the incapacitated person would be able to reach a clear conclusion as to whether proposed treatment was ‘necessary’, but sterilisation and organ donation fell into a category for which “outside scrutiny”⁷⁶ by the courts was essential.

Butler-Sloss LJ on the other hand found no principle, but only a pragmatic approach in the common law. In like manner she found her answer in the realm of public interest, namely that those suffering disability should not be further disadvantaged by being denied treatment.⁷⁷ She considered that sterilisation was in a special, but not unique, category of treatment, which should require court approval.

As to procedure, the Court of Appeal was unanimous that a mere declaration of lawfulness was inappropriate. A declaration changes nothing – it merely states that, had a course of action been taken, it would or would not have been lawful. It has no independent authority. There being no existing procedure for obtaining court approval, Lord Donaldson called upon the Lord Chancellor and the

⁷⁴ p31

⁷⁵ p32

⁷⁶ At p33.

⁷⁷ At p38: “It must be matter of public interest that the same standard of physical and psychological care should be provided to those under a disability as to the general public. I cannot believe that a doctor is to be precluded from exercising his normal duty of care towards such patients, nor do I believe that the equivalent right of the patient to be offered treatment is to be denied to those under a disability.”

Supreme Court Rule Committee urgently to create a new one.⁷⁸ In the meantime he used the court's inherent jurisdiction to regulate its own proceedings to give directions as to how to conduct approval proceedings,⁷⁹ and the other two judges adopted his proposals.

This was all highly creative legal thinking, but it was essentially *obiter*. In fact, the Court of Appeal unanimously⁸⁰ dismissed the Official Solicitor's appeal as Scott Baker J had followed the procedure thought to be appropriate at the time, had investigated the matter fully, and had reached a decision, the wisdom of which no one sought to challenge.⁸¹ Nonetheless, the woeful state of the law had been exposed, and appeal to the House of Lords was inevitable.

The role of the highest court in the land is to clarify the law. Whether the House of Lords achieved that in *Re F* is a moot point. The two leading speeches reached the same conclusion, but they did so by different paths of law:

Lord Goff led the legal analysis. His recognition of the *need* of incapacitated patients to receive treatment, led him to consider the legal justification of necessity.⁸² Looking at the assistance cases, he concluded that emergency is simply a frequent origin of necessity, not a criterion or pre-requisite.⁸³ The basic requirements of the legal exception are simply a need to act when it is not possible to communicate with the assisted person, and that action taken must be such as a reasonable person would take acting in the *best interests* of the assisted person.⁸⁴ Consequently, where incapacity is enduring,

⁷⁸ Under the authority of RSC Ord 80: p21

⁷⁹ p21

⁸⁰ Per Lord Donaldson at p21. Neill J expressly approved the conclusion as to best interests, at p 34. Butler-Sloss J endorsed the declaration, at p43.

⁸¹ By the time the case reached the Court of Appeal, Dr. Campbell was prepared to accept Scott-Baker J's findings that preventing all sexual contact would necessitate such restriction of F's freedom as to be detrimental to her mental health.

⁸² p74, and p77

⁸³ p75

⁸⁴ p76

necessary treatment may transcend emergency procedure and extend even to humdrum matters of simple care.⁸⁵

Lord Brandon agreed that the common law would be defective⁸⁶ if it did not provide an answer to the need for medical care of persons incapable of consenting, but did not find it wanting. With no detailed analysis, he simply asserted that treatment of incompetent patients will be lawful provided that it is in their best interests, which he defined as “carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health.”⁸⁷ Public interest is the broad proposition, but *necessity*⁸⁸ is the justifying principle. He acknowledges that the application of this principle means that the lawfulness of treatment is independent of any involvement of the court.⁸⁹

The others all agreed.

Lord Bridge noted the “paucity of clearly defined principles” in this area, but considered it “axiomatic that treatment which is necessary to preserve life, health or well-being of the patient may lawfully be given without consent.” A rigid criterion of necessity in this context would deprive the incapacitated of treatment which would be entirely beneficial.⁹⁰

Lord Griffiths considered the conclusion justified by an inextricable interrelation of necessity and public interest.⁹¹

⁸⁵ p76. This view seems to foretell the approach later taken in the Mental Capacity Act 2005 – see chapter 6

⁸⁶ p55

⁸⁷ p55

⁸⁸ “Otherwise [incapacitated patients] would be deprived of medical care which they need and to which they are entitled.”: p55

⁸⁹ p56

⁹⁰ pp51, 52

⁹¹ At p69: “Why is it necessary that the mentally incompetent should be given treatment to which they lack capacity to consent? The answer must surely be because it is in the public interest that it should be so.”

Lord Jauncey added nothing substantive.

So, the House of Lords circumvented the basic legal need for consent where consent was not possible on the basis of an exception of ‘necessity’ – but *whose* necessity was the exception meeting? Their Lordships’ vision of the range of treatment authorised by ‘necessity’ was very broad: ‘best interests’ incorporate simple “care”, “improvement of...health”, and “preserv[ation of]... well being”. Such treatments are not *necessary* in the sense of life-preserving; they are merely *desirable* in a civilised world. Yet doctors were showing themselves reluctant to behave in the way desired for fear of legal repercussions. The ‘necessity’ was to provide a legal basis to allow doctors to behave again as we would want. In truth, the ‘necessity’ at the heart of *Re F* is not the patient’s, but the law’s.

The House of Lords construction of a basis for lawful treatment of patients unable to give consent turned out to operate independently of court approval.⁹² The assessment of where the best interests of any given patient lay was to be determined by those responsible for the treatment.⁹³ This rather begged the question of why the court should be involved at all. What exactly is the court’s jurisdiction?

The key to the court’s approach lies in the facts of *Re F*. The treatment in question was sterilisation. Both the higher courts were acutely aware that non-therapeutic sterilisation of the mentally impaired is a procedure with emotive implications and vulnerable to misuse,⁹⁴ and the judges all saw the desirability of some restraining check on physicians. All three judges of the Court of Appeal

⁹² Per Lord Brandon at p 56: “It will...be the duty of the doctors concerned to use their best endeavours to do....that which is in the best interests of such patients. ...The application of the principle which I have described means that the lawfulness of a doctor operating on, or giving other treatment to, an adult patient disabled from giving consent, will depend not on any approval or sanction of a court, but on the question whether the operation or other treatment is in the best interests of the patient concerned.”

⁹³ And so the role to be played by the patient’s family would be determined, not by law, but by medical ethics.

⁹⁴ In Lord Bridge’s view, at p53, special considerations apply to sterilisation or organ donation, only because such treatment “cannot be considered either curative or prophylactic”. For further discussion, see chapter 4 hereafter.

and Lord Griffiths⁹⁵ considered that a common law rule requiring approval of the court should be developed. For the majority in the House of Lords this was a step too far, but, echoing Wood J's resort to medical ethics, they determined that reference to court for independent scrutiny was at least a matter of good practice.

With a need for court involvement perceived, the problem of finding a legal foundation from which it could be exercised remained. **Lords Brandon** and **Goff** frankly observed that the Court of Appeal's proposal of a new rule under Order 80 would lack any jurisdictional basis, because lawfulness of treatment is independent of judicial approval. Rules can only prescribe the procedure for a jurisdiction which already exists. They cannot confer jurisdiction.⁹⁶ The creativity of the Court of Appeal would be *ultra vires*. Declarations were the only option left, and the House of Lords adopted them almost in a spirit of desperation.⁹⁷ **Lord Brandon** took the lead. He asserted that there *is* a jurisdiction to make declarations. It does not come from RSC either Ord 15 r 16 or Ord 80, which are just procedural rules. Rather it is part of the *inherent jurisdiction* of the High Court.

Yet three judges of the Court of Appeal had dismissed declarations as insufficient. Their objections had to be answered:⁹⁸

- (a) The fear that a declaration changes nothing, is effectively toothless, was dismissed as irrelevant. Because lawfulness is independent of court approval, it is not a change that is required. It is rather an order which establishes by judicial process (the "third opinion" which Lord Donaldson sought) whether or not treatment is in the patient's best interests – exactly the purpose of a declaration.⁹⁹

⁹⁵ By analogy with the limited effect of consent in the fighting and sexual perversion cases, he considered (like the Court of Appeal) that a common law rule could be developed to that effect

⁹⁶ Lord Brandon p63; Lord Goff p81

⁹⁷ As Lord Goff later described it, "dismayed by the possibility that the courts might be powerless to provide the necessary guidance to the medical profession, this House had recourse to declaratory relief for that purpose." (*Airedale NHS Trust v. Bland* [1993] 2 WLR 316 at 862)

⁹⁸ p64

⁹⁹ p64

- (b) Although all three judges of the Court of Appeal considered that the public interest dictated a requirement that court should give express approval, which a declaration does not,¹⁰⁰ Lord Brandon dismissed this as semantic. The nature of the enquiry and of the reasoned decision, he said, would be the same.
- (c) Where Neill J¹⁰¹ was concerned that an application may be unopposed, and it is not normal practice to grant declarations by consent, the House of Lords relied on the judge to fill the void. There would always be a summons for directions, when the judge could ensure that all necessary evidence was adduced.¹⁰²
- (d) The concern of Butler-Sloss LJ that a declaration would be of limited efficacy in subsequent litigation¹⁰³ was over-anxious: binding only the parties to the action, as a declaration does, would be sufficient protection.

More telling is Lord Goff's analysis:

“In truth, the objection of the members of the Court of Appeal to the declaratory remedy was that it was not so appropriate as the exercise by the court of the *parens patriae* jurisdiction, had that still been available, by which the court would have considered whether or not to grant approval to the proposed treatment.....If, however, it became the invariable practice of the medical profession not to sterilise an adult woman who is incapacitated from giving her consent unless a declaration that the proposed course of action is lawful is first sought from the court, I can see little, if any, practical difference between seeking the court's approval under the *parens patriae* jurisdiction and seeking a declaration as to the lawfulness of the operation.”¹⁰⁴

¹⁰⁰ Donaldson p20, Neill p33, Butler-Sloss p42

¹⁰¹ p33D-E

¹⁰² p64

¹⁰³ p42

¹⁰⁴ p83

In respect of *Re F* then, the technical solution of the House of Lords was to adapt Lord Donaldson's proposed directions to reflect the inherent jurisdiction origins of the declaratory procedure, and dismiss the appeal. More widely, the decision amounted to the *invention* of a means of court supervision of medical treatment of incapacitated patients. The requirement for court supervision is not one of law, but one of practical reality.

The courts wanted to protect vulnerable patients, from both non-treatment and inappropriate treatment. The medical profession wanted to be protected from hostile legal proceedings. The former was made possible by the latter. A jurisdictional lacuna was overcome by benign collusion between the legal and medical professions: in return for doctors accepting "good practice" requirements which submitted their professional decisions to outside scrutiny, the courts would extend them the protection of its sanction, and simultaneously secure the opportunity to protect patients.

So, at least in its origins, the motivation behind court intervention in medical disputes is one of protection, of patients *and* doctors – arguably a virtue. The legal reasoning, typical of the common law jurisdiction, is close to casuistry. The formulation of the principle of best interests is consequentialist, from the narrow viewpoint of the patient. The principle is then elevated to a deontological status. Where does all this leave the family – for most patients, those who know her best and care for her, and whose own lives will be affected by the need for treatment? Is there any space for an ethic of care?

The common law jurisdiction was built on the duty of the medical profession; that duty is focused on the patient and *her* best interests. Inevitably, therefore, from its conception, the court jurisdiction was also focused on the patient, and a narrow, individualistic conception of the patient at that. The interests of the family are mentioned by one judge, but only in context of good medical practice. As Lord Goff puts it, "no doubt, in practice, a decision may involve others

beside the doctor. It must surely be good practice to consult relatives and others who are concerned with the care of the patient.”¹⁰⁵

If Lord Goff’s comments contain a kernel of recognition that a patient does not live in isolation, he sees the desirability of consulting them in terms of ethics, not law; and even there he is keen to stress the limited impact of any such consultation on the final decision.¹⁰⁶ Lord Jauncey seems to have been thinking of the medics themselves when he baldly states in his closing remarks that “convenience to those charged with his care should never be a justification for the decision to treat,”¹⁰⁷ but in the pejorative tone of this unconsidered remark he sets the court’s face against an issue of very practical concern to the supportive family of the patient. At the beginning of court consideration of cases of this type, the prospects of a role for the family in the decision-making process look very gloomy.

However, judge-made law is not trapped in single expression, as is legislation. The common law changes with the times. Since *Re F* the jurisdiction has been tested, extended and developed in numerous ways. How has the family fared in this progression?

Development of the Jurisdiction after *Re F*

Exclusive determination: The judicial prerogative of determining a patient’s best interests is reinforced by the singular accolade of ‘best’. It was firmly established in the case of *Re S (Adult Patient: Sterilisation)*¹⁰⁸ that, although there may be any number of quite good options, in law there is only one ‘best’. The effect of this is to reduce still further the scope of the family to influence the treatment decision, as the case demonstrated:

¹⁰⁵ p78, but this is a matter of medical ethics, rather than law. (See also footnote 93)

¹⁰⁶ At p78: “It is very difficult, and would be unwise, for a court to do more than stress that, for those involved in these important and sometimes difficult decisions, the overriding consideration is that they should act in the best interests of the person who suffers from the misfortune of being prevented by incapacity from deciding for himself what should be done to his own body, in his own best interests.”

¹⁰⁷ p83

¹⁰⁸ [2001] Fam 15

S was a 29 year old woman with severe learning difficulties and unwise, for a court to do more than stress that, for those involved in these important and sometimes difficult decisions, the overriding consideration is that they should act in the best interests of the person who suffers from the misfortune of being prevented by incapacity from deciding for himself what should be done to his own body, in his own best interests.” a fear of hospitals, who was very distressed by menstrual bleeding. Her mother applied for a declaration that sterilisation or hysterectomy would be lawful in the absence of consent, and the family gave graphic evidence of the difficulties of coping with S’s menstruation. The medical evidence was in favour of a contraceptive coil, which would only ease menstrual flow and required surgery every 5 years. Ward J concluded that the coil would be lawful, but also made the declarations sought, and left the decision of which treatment to adopt for discussion between the mother and the doctors.

S’s family was supportive and caring, trying to cope with the difficult practicalities of S’s condition. The treatment option they preferred met S’s needs, but it also took account of the context of her care, and addressed the needs of the wider family. However, it was not the option preferred by the medics – who did not have to live with the practical consequences. Ward J appears to have been motivated by a desire to give the family’s concern’s maximum sway in the face of medical advice which went against their preferred treatment option.¹⁰⁹

The Court of Appeal firmly rejected his tactic: “judicial decision ought to provide the best answer not a range of alternative answers.”¹¹⁰ The judgment of Butler-Sloss P reveals the court’s true view of the respective interests of family

¹⁰⁹ “The judge appears to have accepted the evidence of the family and friends on these issues in preference to the expert evidence to the contrary in circumstances in which the significance he attached to that family evidence was disproportionate.” Per Butler-Sloss P at p25

¹¹⁰ p27 per Butler-Sloss P

and medics, and the balance of power between them. It could not have been made clearer that, even if the family is taking a *reasonable* view, the ultimate decision is the judge's, and that decision is more influenced by medics than family.

As a matter of law, the approach of Butler-Sloss P may be clear, but as a matter of philosophy and logic it is deeply flawed. As Holm and Edgar point out,¹¹¹ the decision-making process which it assumes is most closely aligned to the von Neumann-Morganstern conception of rational choice, whereby rational decision-makers make the decision that maximises their expected utility; but there is nothing in this model which guarantees a unique best choice. There may be several actions that have the same expected utility; or the outcome that is valued most highly may not be linked to the action that leads to maximising expected utility; or the choice that maximises utility may carry also the risk of greatest loss. Neither is it compatible with consequentialism as an ethical approach, because 'utility' and 'best' have changed meaning. In a consequentialist reckoning, the value given to outcomes is not the value to the decision-maker (ie the patient), but the value to all entities affected by the decision. A truly consequentialist assessment of outcome would consider the impact of the decision on the patient's family as highly material. It would weigh their interests in the balance, not dismiss them as irrelevant.

Holm and Edgar find so little of merit in *Re S*'s insistence on a singular 'best interest' that they are driven to ask "how intelligent persons could ever come to adopt the views put forward by Butler-Sloss P."¹¹² The answer must be found in the question of jurisdiction. Whereas a singular answer is problematic in logic, *in law* quite the reverse is true:¹¹³

"One of the important functions of the judge is to instil into the situation certainty and finality, which the family may well have

¹¹¹ In 'Best Interest: A Philosophical Critique' (2008) Health Care Anal 16 197

¹¹² At p198

¹¹³ See Sheelagh McGuiness, 'Best Interests and Pragmatism' (2008) Health Care Anal 208 at p212.

difficulty in adjusting to but which they can at least accept as the judgment of the appointed impartial authority. Equally it is the function of the judge to protect the medical professions from the threat of criminal or civil proceedings as a consequence of the exercise of their best endeavours. It is simply not helpful for either the family or the doctors to be presented with a declaration that two or more possible alternatives are lawful.”¹¹⁴

Butler-Sloss P could call in defence of her obvious intelligence Coggan’s¹¹⁵ distinction between ‘theoretical truth’ and ‘practical truth’. Where a disagreement in respect of the treatment of an incapacitated person exists, there must be a mechanism for resolution. The inherent jurisdiction is that mechanism, and the courts are determined that decision-making authority is to be theirs alone.

Use of force: Patients who lack the capacity to consent do not necessarily lack the capacity to express a view, and sometimes that view is contrary to the assessment of their best interests. How then is the medic to put his assessment of best interests into effect? If doctors are not to retreat again into self-defensive inaction, the court jurisdiction needed also to extend them protection from liability for the use of force.

The issue was tested in the case of *Norfolk & Norwich Healthcare Trust v. W*:¹¹⁶

A patient arrived at the hospital in labour, but denying that she was pregnant. The medical assessment was that the baby would be stillborn if not delivered quickly, so the obstetrician wanted to use forceps or, if that should fail, emergency Caesarean procedures. A psychiatrist gave evidence that she lacked capacity to consent.

¹¹⁴ p30-31

¹¹⁵ In ‘Best Interests, Public Interest, and the Power of the Medical Profession’ (2008) Health Care Anal 219 at p220.

¹¹⁶ [1996] 2 FLR 613

Johnson J held that both continued labour and the death of the foetus would have serious consequences for the health of the patient, so the proposed rapid delivery was in her best interests. The use of reasonable force to achieve it was lawful, simply as a logical extension of Lord Goff's principle of necessity.¹¹⁷

If there had ever been any doubt about it, the extension of the court's jurisdiction to provide authority for the use of force made it abundantly clear that the courts were serious about enabling their decisions to be brought into reality. The role of the incapacitated patient, and by extension the family, is simply to abide by it.

Interim orders: Sometimes a decision is needed urgently, to secure the position until there is time to consider issues fully. In the context of treatment decisions for incompetent patients, there was a jurisdictional problem with this, because hitherto it had always been considered that declarations were not available on an interim basis.¹¹⁸ The intellectual objection to interim declarations is the possibility that those factors which determine lawfulness of treatment, namely incapacity and best interests, may change in the time between making the declaration and administering the treatment.

However Part 25.1(1)(b) of the Civil Procedure Rules 1998 introduced to English law the concept of an interim declaration. Although the Notes to Part 52 make clear that the Law Commission had recommended such relief in the context of judicial review proceedings, the Rules conferred the power without limitation. It was not long before the possibility of applying the new rule to declarations under the inherent jurisdiction was raised. In *NHS Trust v. T (Adult Patient: Refusal of medical treatment)*:¹¹⁹

T suffered borderline personality disorder. She had a history of self-harm by blood-letting, to the extent that transfusion was necessary to

¹¹⁷ p 615

¹¹⁸ For earlier non-availability of interim declarations, see *F v. Riverside Mental Health NHS Trust* (1994) 20 BMLR 1; and *St George's Healthcare NHS Trust S* [1999] Fam 26 at 61.

¹¹⁹ [2004] 3 FCR 297

save her life. She had previously been persuaded to consent to such treatment, but in January 2004 she signed an advance directive refusing it, giving her reason as belief that blood carries evil around her body. In April 2004 the need for blood transfusion again arose. Pauffley J declared that such treatment would be lawful in the present emergency circumstances (it was administered, and T recovered); and the matter should be relisted for directions for consideration of lawfulness in the future. When it came before Charles J for directions, the medical authority in effect sought an interim declaration.

Charles J emphasised that an interim exercise of the court's jurisdiction required the same legal foundation as a final decision: lack of capacity and necessity. It was an unusual feature of the case that the usual uncertainties were largely absent: all parties agreed that the patient's mental condition was most probably permanent and the urgent need for treatment would arise again in the same way. The judge found sufficient evidence to satisfy him both that the patient lacked capacity and that treatment would be in her best interests, and he therefore made the declaration sought.

However Charles J also recognised that more and better evidence was possible, that such further evidence should be put before the court if it is to reach a proper decision, and that the conclusion after consideration of such further evidence may be different¹²⁰. The interim declaration was therefore seen and used as a holding device, itself protective of the protective jurisdiction.

The absorption of interim powers into the inherent jurisdiction demonstrates the court's concern to maintain maximum flexibility. Interim powers are a useful addition to the declaratory armoury, which ensure that the court can take determinative control of a case – for the protection of patients and doctors, and to the exclusion of the family – at the earliest appropriate moment.

¹²⁰ Para 51

Interplay with statute: It is not just the common law which has, at various times in the last half century, been preoccupied with the affairs of mentally incapacitated adults. Parliament too has made provisions, and so the interplay of the declaratory and statutory jurisdictions had to be worked out.

In respect of formally detained patients, statute impacts on inherent jurisdiction through section 63 of the Mental Health Act 1983. That provision removes the requirement for consent to medical treatment which is given in respect of the mental disorder for which the patient is detained, as long as such treatment is given under the direction of the approved clinician. A problem arises because a mental disorder which leads to detention may nonetheless leave the patient's capacity to consent intact. The effect of s63 is to limit the autonomy of detained patients with unimpaired capacity to treatments which are independent of their mental illness or disorder.

The impact of this was demonstrated in the case of *LB v. London Borough of Croydon*.¹²¹

LB was a 24 year old woman, who had been abused in childhood and now suffered personality disorder, which manifested itself in self-harming behaviour. When detained, she was removed from any opportunity to self-harm in her usual ways, so she denied herself food instead. She applied for a declaration that she should not be fed medically against her will. Although immediate crisis was averted because she was persuaded to take some food again, both LB and the Local Authority wanted to know if tube feeding would have been lawful, to guide future treatment.

The courts had no doubt that feeding by naso-gastric tube amounted to medical treatment within the meaning of the statute;¹²² or that such treatment would be

¹²¹ [1995] 1 FCR 332. See also *Tameside & Glossop Acute Services Trust v. CH* [1996] 1 FLR 762.

¹²² Per Thorpe J at p 344; per Hoffman LJ at 138

directed towards the psychopathic disorder which had led to detention.¹²³ Thorpe J however found that LB had capacity to make a proper decision in respect of the proposed treatment,¹²⁴ and she had decided to refuse it. He further held that, if his conclusion as to capacity was wrong, forcefeeding would not be in her best interests unless and until her physical state was so debilitated as to threaten her survival.¹²⁵

At common law, the effect of these findings would be that the proposed naso-gastric feeding was lawful only in extreme circumstances. However Thorpe J had little difficulty recognising that s63 dispensed with any need for LB's consent: statute "legalize[d] what the common law would not."¹²⁶ The Act of Parliament was a good deal less liberal, less protective of individual autonomy, than was the common law, but it prevailed, as the Court of Appeal confirmed.

Thorpe J found this statutory limitation on autonomy "disquieting,"¹²⁷ and he questioned the fairness of it. His concern was clearly for the weakness of the position into which it puts the competent but mentally ill patient. He was mollified only a little by the Official Solicitor's reminder that a Code of Practice requires the professionals to seek consent from patients with capacity, even if the treatment falls within s63.¹²⁸

In terms of the common law jurisdiction's comparison with statute, Thorpe J's findings on capacity and criticism of the treatment regime show a more sensitive

¹²³ Per Thorpe J at 345; And per Hoffman LJ at 138-139, "a range of acts ancillary to the core treatment fall within the definition....It does not follow that every act which forms part of that treatment....must in itself be likely to alleviate or prevent a deterioration of that disorder...It would seem strange if a hospital could, without the patient's consent, give him treatment directed to alleviating a psychopathic disorder showing itself in suicidal tendencies, but not without such consent be able to treat the consequences of a suicide attempt."

¹²⁴ p343

¹²⁵ p344. He distinguishes LB's personality disorder from anorexia nervosa. LB's refusal was an expression of her core personality. She would regard the proposed treatment as a repetition of the invasive abuse of her childhood. The consequence of treatment would therefore be to magnify the disorder and reduce the prognosis for the only known treatment, namely psychotherapy. She was driven to her current position by a restrictive care regime and absence of care plan.

¹²⁶ p345

¹²⁷ p345

¹²⁸ p345

appreciation of the subtleties of the disorder than the operation of s63 insists on; and an attempt to facilitate treatment by empowering, rather than overpowering, the patient. However his ultimate acknowledgment that best interests point to survival confirms a deontological value, reminiscent of the original understanding of ‘necessity’.

The Court of Appeal was less discomforted by the case, seemingly because it did not share Thorpe J’s view of LB’s capacity.¹²⁹ Nonetheless, the mood of both courts’ judgments expresses a protective instinct. The ceding of jurisdiction is not accompanied by any ceding of moral compass; it is simply a matter of due process.

Ceding jurisdiction to parliamentary priority extends further than direct statutory provision, to encompass also the parliamentary delegation of discretion, as was demonstrated in *A v. A Health Authority*.¹³⁰ A declaration is effective “between the parties to the proceedings in which it was made, as a conclusive definition of their legal rights.”¹³¹ Consequently, and by analogy to the recognised limits on the theoretically limitless jurisdiction of wardship,¹³² the courts will refuse a declaration under the inherent jurisdiction that would be coercive on a Local Authority, unless the court is satisfied that it does not encroach on the authority’s public law functions or, if it does, that such encroachment can be justified on public law grounds.

However, concession to parliamentary authority is not automatic. Where the statutory intention was less concrete, the courts have demonstrated a determination to extend their protective jurisdiction beyond controversial issues of surgery, into areas of mundane, everyday care (as Lord Goff had foreseen). In the case of *Re F (Adult: Court’s Jurisdiction)*:¹³³

¹²⁹ Hoffmann LJ at p 140; Neill J at p142

¹³⁰ [2002] Fam 213

¹³¹ Per Judge LJ in *St George’s Healthcare NHS Trust v. S* [1999] Fam 26 at p59, as quoted by Munby J in *A v. A Health Authority* [2002] Fam 213.

¹³² For example, a Local Authority’s decision on adoption in *A v. Liverpool City Council* [1982] AC 363

¹³³ [2000] 2 FLR 512

F was a mentally incapacitated adult, one of 8 siblings who had been taken into care on the basis of seriously inadequate parenting. Her mother sought her return home. An earlier hearing had determined that F was outside the guardianship provisions of the Mental Health Act, so the Local Authority sought a declaration under the inherent jurisdiction that it would be in F's best interests to remain in their care. Johnson J held as a preliminary issue that the court had declaratory jurisdiction, and the mother appealed on the basis that the statutory regime had ousted the common law powers.

The judgments traced the development of the statutory powers. In their original form,¹³⁴ the statutory powers of guardianship would have met F's needs,¹³⁵ but (as has already been noted) later statutory provisions narrowed the definition of susceptible persons.¹³⁶ It was acknowledged that this restriction had been a matter of legislative policy,¹³⁷ to reduce the extent of state interference in private lives; but the judges unanimously *rejected* mother's submission that curtailment of guardianship simultaneously implied ouster of common law jurisdiction.

Butler-Sloss P saw the statutory and common law jurisdictions as parallel, rather than intersecting:

“..the guardianship provisions in the 1959 Act...were clearly neither comprehensive nor exhaustive and did not cover a multitude of everyday activities in which decisions are made on behalf of a person unable to decide for him/herself...The effect of the 1982 changes was, inter alia, to reduce the number of people susceptible to the guardianship regime. It did nothing to change the situation of the

¹³⁴ s33 of the Mental Health Act 1959 (that which killed *parens patriae*) created powers of Guardianship (broadly equivalent to the powers of a father over a child under the age of 14) in respect of a person under the age of 21 and suffering psychopathic disorder or subnormality of a nature and degree to warrant it.

¹³⁵ Per Butler-Sloss P at p515

¹³⁶ By substituting the term “mental impairment” in place of “subnormality”, and requiring the impairment to be associated with abnormally aggressive or seriously irresponsible conduct: The Mental Health (Amendment) Act 1982 and the Mental Health Act 1983.

¹³⁷ Butler-Sloss P quotes Lord Elton's introduction of the proposed changes to Parliament at p515

day-to-day care of the mentally incapacitated adult...the English mental health legislation does not cover the day-to-day affairs of the mentally incapacitated adult, and the doctrine of necessity may properly be invoked side by side with the statutory regime.”¹³⁸

Sedley LJ took a more circumspect view. Recognising the restrictive purpose of the legislative policy behind the guardianship amendments, he accepted that the mother’s case would have been unanswerable if heard in the immediate aftermath of amendment.¹³⁹ However, relying on the inexorable march of time, and the consultative documents preceding the Mental Capacity Act, he concluded that the legislature had since had a further change of heart. Where guardianship was formerly seen as a restriction of civil liberties, recognition of its benign aspects was again being rediscovered: “what was once an eloquent silence has with the passage of time and events acquired the character of an uncovenanted gap in provision for the incapacitated”¹⁴⁰- and the historic interplay of court and Parliament is to fill each other’s gaps.

Thorpe LJ did not answer the mother’s argument squarely. His agreement with the other two judgments was based on conviction that a finding of no jurisdiction would be “a sad failure”,¹⁴¹ and he was “encouraged to the rejection of an outcome which [he] regard[ed] as unpalatable”¹⁴² simply by citation of cases which emphasise the protective purpose of the inherent jurisdiction. In the end, he simply refused to allow the protective impulse of the court to be swept away on a tide of liberal legislation.¹⁴³

¹³⁸ p522

¹³⁹ At p530: “The court would have had to confront the fact that it was being asked to sanction state intervention in a situation which Parliament had recently removed from the state’s sphere of influence.”

¹⁴⁰ p531

¹⁴¹ p527

¹⁴² p527

¹⁴³ At p527: “Of course regimes of guardianship whether statutory or inherent in their foundation can be operated so as to impinge upon or deny the rights of the individual. To minimise that risk powers contained in the 1959 Act were drastically reduced and both in statute and codes of practice safeguards are declared for the protection of the individual against error, abuse or excess in the protector. In my judgment *it cannot follow* (italics added) that that reduction intended to benefit patients must operate consequentially to deny patients the protective aspects of guardianship which the common law is able to furnish...”

What unifies the judgments is a determination to ensure that the interests of vulnerable adults are not left in a vacuum. Where F should live and be cared for represented a serious justiciable issue, with no practical alternative to court intervention. If the court could not act, vulnerable people would, like F, “be left at serious risk with no recourse to protection, other than the future possibility of criminal law.”¹⁴⁴ It is the consequentialist approach on a protective principle writ large. Moreover, it is an extension of inherent jurisdiction taken with an attitude of suspicion towards families very much in the forefront of the judicial mind. That suspicion may have been justified on the particular facts, but the attitude permeates the judicial thinking, and its ripples extend beyond the instant case, to families in general.

So, when the inherent jurisdiction is pitted against statute, it cedes authority where necessary, but also extends its reach where it can. Yet this is no power struggle, no competition for jurisdictional turf. Time and again, the court calls for *more* statutory intervention,¹⁴⁵ for Parliament to take responsibility for the jurisdiction which the courts have forged out of a sense of necessity – as of course it now has, in the form of the Mental Capacity Act 2005. Statutory reform was not the defeat of the inherent jurisdiction, but the triumph of judicial campaigning, for if the courts felt the need of a jurisdiction protective of both patients and doctors, they were also aware of the limited ability of their own creation to meet that need.

Discovering the limitations: It is an unavoidable feature of the law as the House of Lords declared it in *Re F* that the lawfulness or otherwise of the treatment act is independent of court approval. A declaration changes nothing, but it entails independent scrutiny and a third party opinion, so doctors rely on it as evidence that their actions fulfil common law requirements. Insofar as the declaratory procedure was conceived to protect doctors, it is significantly flawed by the fact

¹⁴⁴ Butler-Sloss P at p 523

¹⁴⁵ See for example, Butler-Sloss P in *Re F (Adult: Court’s Jurisdiction)* at p531, and Charles J *NHS Trust v. T (Adult Patient: Refusal of medical treatment)* at para 74. To reinforce his call for statutory reconsideration, Charles J even adds an extensive tailpiece to his judgment, spelling out the implications of development of the inherent jurisdiction.

that a declaration can be wrong. If challenged and revoked, the doctor who has acted in reliance on it is left unprotected.

This flaw in the jurisdiction was tested in the case of *St George's Healthcare NHS Trust v. S.*¹⁴⁶

S presented at her GP's surgery 36 weeks pregnant and suffering from pre-eclampsia. She was advised that the baby needed to be delivered urgently, otherwise the lives of both S and baby would be at risk. She rejected that advice. The GP arranged for her to see an approved social worker, who arranged for S's compulsory admission in hospital under s2 Mental Health Act 1983. From there S was transferred to a maternity unit, and ex parte application was made to court seeking authorisation of Caesarean delivery without consent. Hogg J granted the declaration, and the baby was born healthily. S subsequently appealed the declaration and applied for judicial review of the decisions of the social worker and hospital authorities.

The case revealed a woeful disregard for legal requirements of compulsory detention in the urge to preserve lives, which effectively robbed Hogg J's declarations of any value. As Judge LJ put it,

“It is inappropriate to describe the order as void, or made without jurisdiction. But it is an order which MS is entitled to have set aside as ex debito justitiae. This may involve some unfairness to the doctors and nurses at St. George's who were all conscientiously, and in very anxious circumstances, seeking to do the right thing. But the unfairness (indeed, injustice) to MS would be very much greater if the order were not set aside.....While it may be available to defeat any claim based on aggravated or exemplary damages, in the extraordinary circumstances of this case the declaration provides no

¹⁴⁶ [1999] Fam 26

defence to the claim for damages for trespass against St. George's Hospital.”¹⁴⁷

If there had been any doubt, these conclusions make clear that the court's protective priority is the patient, not the doctor. Affording legal protection to medics was intended to encourage them to act, but not to act officiously. The courts' instinct is to protect incapacitated patients from too much medical interference, as well as too little. The inherent jurisdiction will not protect doctors who overstep the mark. This offers patients the hope of redress, but it is no comfort to families, who may feel instead that doctors could be better constrained by a more balanced approach to decision-making authority.

Equally, the inherent jurisdiction will not offer *hypothetical* protection. The foundation of the jurisdiction in an assessment of best interests means that the declaratory procedure operates on a snapshot of time. With the infinite variety of people's lives and medical conditions, it is inevitable that the same procedure which is in a given patient's interests now, may not be in six months time. Consequently the procedure is not fitted for advance or hypothetical decisions, however protective they may seem to be.

Both the human urge to seek such a declaration, and the impossibility of safely granting one, were illustrated in the case of *R v. Portsmouth Hospitals NHS Trust ex p Glass*.¹⁴⁸

The hospital took the view that a severely disabled 12 year old child was dying, and wanted to administer morphine (which depresses respiratory function) to alleviate distress. His mother refused consent, but the treatment was commenced, leading to violence between family members and hospital staff. Meanwhile other family members resuscitated the child themselves, and he recovered. The mother sought, inter alia, declarations of what would constitute

¹⁴⁷ p62

¹⁴⁸ [1999] 3 FCR 145

lawful treatment should she ever need to take the child to that same hospital again.

Woolf LJ was sympathetic to Mrs. Glass' desire for reassurance¹⁴⁹ - after all, she had already demonstrated once that her view of appropriate medical treatment brought about a better result for the child than would have the hospital's - but he had no doubt that it would be inappropriate for the court to grant the declarations she sought:

“For the court to act in anticipation in this area to try and produce clarity where, alas, there is no clarity at the moment, would ...be a task fraught with danger....The answer which will be given in relation to a particular problem dealing with a particular set of circumstances, is a much better answer than an answer given in advance.”¹⁵⁰

On the other hand, courts seem willing to take a different approach where it is not the most appropriate treatment plan which is unforeseeable, but the circumstances when it will be necessary to put it into effect. Once the court has decided to make a declaration that invasive resuscitative procedures are not in a patient's 'best interests', uncertainty about when the doctors may be able to rely on it can be remedied by the simple expedient of attaching an expert (medical) report to the court order, as it did in the case of *Re B (Medical Treatment)*.¹⁵¹ There is clearly an imbalance between a family's ability to secure prospective support of the court, and the medics'.

¹⁴⁹ p151. In fact, Mrs. Glass was clearly right in her refusal to trust the relevant medical expertise. As was observed by Judge Casadevall in a separate opinion after the hearing at the European Court of Human Rights, “the facts have shown - nearly six years later and to date – that, in the particular circumstances of the present case, maternal instinct has had more weight than medical opinion.”, *Glass v. UK* [2004] 1 FCR 553, at para 2.

¹⁵⁰ p151

¹⁵¹ [2008] EWHC 1996, Coleridge J presiding.

Conclusions

The court's jurisdiction to determine medical treatment disputes begins with the torts of battery and trespass to the person. The principle of physical inviolability requires that, to be lawful, medical treatment depends on the consent of the patient. Where the patient is unable to consent, if the expectations of modern civilised society are to be met, that principle requires modification.

The modifications adopted depend on the source of the incapacity. Where the patient is a child, the law includes the power of consent in the bundle of parental responsibilities. If the parental decision is challenged, the court has modern statutory powers to decide the question according to the child's welfare, or ancient powers of *parens patriae* to decide according to his best interests. Where the patient is an adult, both of those jurisdictions were extinguished, and a gap in the law arose.

To fill that gap the House of Lords in *Re F* created a new legal authority for medical treatment of patients unable to give consent, purportedly on the basis of the common law defence of 'necessity'. In truth, the necessity at the heart of *Re F* was the law's, not the patient's, as it encompassed much more than life-saving treatment. The 'necessity' of providing treatment for those unable to give consent was located in a doctor's duty to act in his patient's best interests. The lawfulness of treatment was logically therefore independent of court authority, but an unfettered discretion of doctors was thought to be undesirable. Assumption of the power to scrutinise medical decisions was the court's trade-off for extending to medics protection from legal action.

The modifications of the general law principle which were found, or created, in respect of both children and adults are then both based in the notion of the 'best interests' of the person lacking capacity. In respect of children, the understanding of 'best interests' was shaped by the context of an ancient jurisdiction which represented a property privilege as much as a protective duty; and in respect of adults by the context of a quasi-contractual relationship of patient and doctor. Both of these contexts foster a narrow, individualistic concept

of the person lacking capacity. In adopting the criteria of these contexts, the law inevitably also adopted their narrow concept. This left families largely excluded. Once a treatment decision is in the hands of the court, the role of the patient's family was originally conceived as marginal. They may provide information, and are expected to live with the consequences, but their own preferences and their own interests are not part of the legal consideration.

However, the inherent jurisdiction is supremely adaptable, as its development in respect of the use of force, interim orders and statutory interplay demonstrate. If it can encompass coercion, update its procedures and extend its boundaries, it can also adapt its understanding of the concept of 'best interests'. If it were to be accepted that a patient is best served, not by an individualistic assessment of her interests, but by weighing those interests in the context of *family*, then the inherent jurisdiction *could* flex to accommodate this more sympathetic vision – as the following chapter demonstrates.

Chapter 4

“Best Interests” In The Courts

This chapter examines the court understanding of ‘best interests’ in the context of medical treatment disputes decided under the inherent jurisdiction. Categorising authorities by their central issue reveals four main groups, involving respectively issues of sterilisation, life-preservation, borderline capacity and religious belief.

Each category raises special moral or ethical issues, revealing the existence of fundamental judicial assumptions or values, which have shaped the court interpretation of ‘best interests’ and have an influence beyond the boundaries of their origins. The effect of these preoccupations has been to limit the role of the family in the medical decision-making process, in a way which is neither necessary nor appropriate. Understanding where the limitations come from enables us to reconceive ‘best interests’ in the medical context. Comparison with a related area of law, namely paternity testing, then demonstrates that a wider interpretation of the concept, more sympathetic to families, is both workable and desirable.

Decisions about medical treatment are taken countless times every day in hospital corridors, surgery consulting rooms, and private homes up and down the country. Usually reaching a determination is a fairly informal process, in which those most closely connected with the patient contribute to varying degrees according to the circumstances of the case. Adapting Lord Donaldson’s account¹ of the process, it may be said that no single person dictates a patient’s treatment plan, because there are checks and balances in the process. The doctors can

¹ *Re J (A Minor)(Wardship: Medical Treatment)* [1991] Fam 33 at p41

recommend treatment A in preference to treatment B, and they can refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. Patients for their part can refuse to consent to treatment A or B or both, but cannot insist on treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision².

However, when the treatment concerns a patient who cannot give consent, the balance of power shifts. A physician's professional code of ethics requires her to consider the family's views³ before reaching a determination of the patient's 'best interests', but having so considered, ultimately the treatment decision is hers alone.

If others involved in the care of the patient disagree with the doctor's decisions, for resolution of the dispute they must refer the matter to court. The balance of power then shifts again. This time, the judge assumes the sole right to determine the patient's best interests.

A judge presented with the responsibility of determining the patient's 'best interests' is unlikely to have any medical expertise, and will be a stranger to the individual whose life course he now determines. A position of equal ignorance in respect of both sides of the disagreement does not, however, imply the extension of equal regard to their views. Bound by respect for professional medical judgment and ethics, the court can only choose between treatments recommended by the doctor, or no treatment at all. It cannot insist on treatment C,⁴ because the medical profession retains supremacy in matters of medical

² Huxtable puts it rather less generously: "English law does not simply require the doctors to grant you whatever you want; instead, you will only get what you want if it is, first, something the doctors agree that you need.": 'Whatever You Want? Beyond the Patient in Medical Law (2008) Health Care Anal 288 at 293.

³ The GMC Guidance document 'Consent: Patients and Doctors Making Decisions Together' at paragraph 76(f) directs doctors to consider "the views of people close to the patient on ...whether they consider the proposed treatment to be in the patient's best interests."

⁴ See the Court of Appeal decision in *R v. Portsmouth Hospitals NHS Trust ex p Glass* [1999] 3 FCR 145 and Per Cazalet J in *A NHS Trust v. D* [2000] 2 FLR 677: "There can be no question of the court directing a doctor to provide treatment which he or she is unwilling to give and which is contrary to that doctor's clinical judgment."

judgment. In contrast, the family *loses* any supremacy it may have thought it had from knowing the patient best. The judge can override completely the views of the patient's family.⁵ Even hearing them is merely a matter of good practice and tact. The result is an imbalance in the operation of inherent jurisdiction: the views of medical experts have an in-built influence, and the views of the family an in-built marginalisation.

This imbalance in influence of the two primary sources of information to the court itself says much about judicial assessments of 'best interests', but in the nature of common law, as cases have been decided and binding precedents established, it has become possible to discern other formative factors too. If decided cases are grouped together according to their central issue, they fall into four categories: namely issues of sterilisation, life-preserving treatment, borderline capacity and religious belief. Each of these categories raises particular moral or ethical issues, and court determination of them reveals special judicial assumptions or axioms at play. Given the universal application of the 'best interests' test, these special preoccupations, pertinent to a particular category of cases, are carried over into other categories too, where their pertinence may be rather less obvious. And so the concept develops.

A snapshot representation of the judicial development of the concept of 'best interests' can be found in the grid at Appendix One, but to identify the preoccupations which have shaped the concept, it is instructive to consider each of the categories in turn.

A. Sterilisation

Paradoxically, it was sterilisation which gave birth to the inherent jurisdiction. As the issues which surgical sterilisation raises have been explored, and the

⁵ See for example, *An NHS Trust v. X* [2005] EWCA Civ 1145 and *W Healthcare NHS Trust v. H* [2005] 1 WLR 834. In *Re S (Adult Patient: Sterilisation)* [2001] Fam 15 the Court of Appeal overturned the first instance decision, on the basis that the judge had given too much weight to family concerns!

advancement of science has offered less invasive means of securing the same effect, the frequency of its appearances in the law reports has diminished, to the point where sterilisation cases no longer represent a great time burden for the courts. However, its early centrality to the development of the court jurisdiction has given it a formative role in developing the judicial perception of best interests.

As a medical procedure, sterilisation has special features⁶ which distinguish it from other interventions:

Extinguishing a basic right: The very purpose of sterilisation is to exclude what many people see as a fundamental right of existence, namely the right to reproduce. (For court purposes there is a distinction between sterilisation which is incidental to therapeutic treatment, and sterilisation for its own sake;⁷ and it is only the latter with which courts are concerned.⁸) In itself, this gives rise to moral and emotional considerations of importance.

The court upholds the importance of the right to reproduce where there is scope to benefit from that right,⁹ but is surprisingly willing to go behind the notion and look to the *content* of such rights. Where mental incapacity renders them empty and unexercisable, the emotive aspect of overriding reproductive ‘rights’ is rapidly dismissed, as it was in *Re B*,¹⁰ and has been ever since. Holman J in *Re*

⁶ See *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 per Lord Brandon at p57, per Lord Goff at p79.

⁷ “...there is a real distinction between medical treatment undertaken with a view to securing abortion or sterilisation and that undertaken for a different purpose, for example the excision of a malignant tumour, which has this incidental result. It is only the former type of treatment which the law regards as being in a special category, probably because of its irreversible and emotive character in the light of the history of our times.” Per Lord Donaldson in *Re F* at p 19.

⁸ *Re GF (Medical Treatment)* [1992] 1 FLR 293. In conversation with the office of the Official Solicitor, the OS perception is that the rarity of litigated cases in recent years may be due to clearer designation by medics concerned of a therapeutic purpose for the operation.

⁹ As in *Re D* [1976] Fam 185, where the patient, aged only 11 at the time of the sterilisation application, was considered to have capacity to marry in due course. Heilbron J refused the application, and all the judges who have later considered her decision have been robust in their approval of the refusal. See for example Lord Donaldson in *Re F* at p 19; Lord Hailsham in *Re B (A Minor)(Wardship: Sterilisation)* [1988] AC 199 at p 204; Lord Oliver in *Re B* at p211; Butler-Sloss P in *Re A (Male Sterilisation)* [2000] 1 FLR 549 at 556.

¹⁰ [1988] AC 199. Per Lord Hailsham at 204: “...this right is only such when the reproduction is the result of informed choice of which this ward is incapable.” Per Lord Oliver at 219: “...the right to reproduce is of value only if accompanied by the ability to make a choice and in the

X¹¹ was prepared to operate away the right to reproduce even in the face of a patient's expressed desire to have a baby, because

“X is quite unable to make any sensible, informed decision for herself, so other people have to make it for her. Even though subjectively she feels she would like to have a baby, it remains objectively completely contrary to *her* (I emphasise the word *her*) best interests to do so.”¹²

Yet the same could be said of many competent people's decision to have a baby. Babies are conceived and born in unwise circumstances every day, as the tabloid newspapers testify. Paternalism¹³ is at play here, enforcing on those who lack capacity a standard of decision-making higher than that which is expected of competent people.

Permanence: Sterilisation is usually considered to be permanent – an irreversible interference with healthy organs. As such, it is a matter on which medical opinions are not unanimous, and therefore a matter of importance to the courts.¹⁴

As medical science advanced, and reversible sterilisation procedures became possible, the courts gave something of a sigh of relief.¹⁵ The intervention they were asked to sanction thereby became less draconian, and the responsibility assumed in giving sanction therefore less onerous.

instant case there is no question of the minor ever being able to make such a choice or indeed to appreciate the need to make one.”

¹¹ *Re X (Adult patient: Sterilisation)* [1999] 3 FCR 426

¹² At p431

¹³ Andrew Bainham, in ‘Handicapped Girls and Judicial Parents’ [1987] LQR 334, sees it in the more complex terms of contradictory rights: “A sophisticated theory of children's rights must recognise the existence of the child's protective interests alongside her interest in self-determination. Lord Hailsham's speech [in *Re B*] may therefore be interpreted as indicating that, in the case of severe handicap, the former interest outweighs the latter.”

¹⁴ For example *Re D* at p195, *Re X* at p431

¹⁵ For example, *Re M (A Minor)(Wardship: Sterilisation)* [1988] 2 FLR 497 per Bush J at p497.

Yet in reality it is never suggested that the procedure ever *would* be reversed, and the medical evidence is sometimes even explicitly against reversal.¹⁶ It is hard to imagine a factual scenario where sterilisation would be in the patient's best interests in the first place but yet its subsequent reversal is plausible.¹⁷ If the woman is competent to consent to reversal surgery herself, then her incapacity at the time of the sterilization was only temporary, and the operation should never have been sanctioned in the first place. If she is subject to court jurisdiction on the question of reversal, she must necessarily lack capacity now. If she lacks capacity to consent to surgery, it would be illogical for a court to hold that restoring the possibility of parenthood, with its myriad responsibilities, would be in her best interests. Such simple reasoning demonstrates that, if the concern about permanency has validity, it is in truth an ethical, rather than a practical problem; and therefore the apparent relief offered by reversal procedures is illusory.

Historic Misuse: Sterilisation procedures cannot be isolated from the history of their eugenic use,¹⁸ which modern social conditions condemn and abhor. The very cases with which the court is concerned, namely patients who are mentally defective, are those where modern European and American history is most shameful. It is worth remembering that the judges¹⁹ who decided the leading

¹⁶ *Re P (A Minor)(Wardship: Sterilisation)* [1989] 1 FLR 182, in which (at p 193) Dr. Heller regarded the question of reversibility as “academic, because it was his strongly held view that T should never have a child and, therefore, he could not see the point of any reversal operation.”

¹⁷ The only clear justification for reversal would be if the patient regained competence, but if there was ever any possibility of that occurring, it could not be said that the original sterilisation was appropriately carried out, as envisaged by Lords Hailsham and Oliver in *Re B*.

¹⁸ The most notorious expression of court sanctioned sterilization for eugenic purposes is the judgment of Justice Holmes in the American Supreme Court case of *Buck v. Bell* (1927) 274 US 200 at 207: “It is better for all the world if, instead of waiting to execute degenerate offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind...Three generations of imbeciles are enough.” In fact, Carrie Buck was a young woman of normal intelligence who had been institutionalised not because of mental retardation, but to hide the shame of pregnancy – a pregnancy that resulted from rape. Moreover, Carrie Buck's mother was only mildly mentally retarded, and Carrie's child was not retarded at all. Seventy-five years after the Supreme Court sanctioned Carrie's sterilisation, Mark R. Warner, the state governor of Virginia, formally apologised for the abuses of the case. See SJ Gould, ‘Carrie Buck's Daughter’ in *The Flamingo's Smile; Reflections in Natural History* and Burgdorf & Burgdorf, ‘The Wicked Witch Is Nearly Dead: *Buck v. Bell* and the sterilisation of Handicapped Persons.’ Temple Law Q (5) 995

¹⁹ Heilbron J (*Re D*) was born in 1914; Lords Hailsham, Bridge, Brandon, Templeman, Oliver, Donaldson, Goff and Jauncey (*Re B* and *Re F*) were born in 1907, 1917, 1920, 1920, 1921, 1920, 1926 and 1925 respectively, and all of them served in World War II.

cases on the use of sterilisation on patients lacking capacity had all lived through an era where eugenicist views were not uncommon in England, and then through the Second World War, where the full horror of such arguments were made plain. The collective judicial memory was conscious of the need to avoid both eugenicist considerations and the perception of them,²⁰ and has remained so.²¹

This aspect of sterilisation explains the strength of judicial support for the earliest reported decision, that of *Re D*, where the mother's views were expressly founded on the social undesirability (as she saw it) of D ever conceiving a child,²² and the doctor was seen to have lost his impartiality by over-identification²³ with the mother. Heilbron J would have preferred that D's carers even consider abortion,²⁴ rather than pursue sterilisation for social ends.

And yet in *Re M*²⁵ there is, behind the rhetoric, more than a hint of considering the practical implications of another generation of disabled children. In the same paragraph as warning against eugenics, Bush J used an argument which has clear eugenic overtones to explain where M's best interests lay:

“If [M] were pregnant then she would have to be monitored even more closely than any normal healthy adult because of this 50% chance of [the disability] being handed on to any child she might bear. Tests would have to take place, which would be very

²⁰ As Bush J put it in *Re M (A Minor)(Wardship: Sterilisation)* [1988] 2 FLR 497 at p 499: “We are the victims of the European history of operations of this kind in the way in which some countries and some regimes have misused this kind of operation for eugenic purposes. It is, therefore, right that we in this country should be particularly watchful that we do not go down that road, and that people should not be sterilised merely because they are severely handicapped or weak, or likely to give birth to a child who may equally be so.”

²¹ Even the late cases continue to emphasise their distance from eugenic considerations: eg *Re X* [1999] 3 FCR 426 at 431, *Re S (Adult: sterilisation)* [1999] 277 at 279.

²² D's mother was “worried lest D might be seduced and give birth to a baby which might also be abnormal...She had always believed that D would not, or should not, marry.” (p190)

²³ “Dr Gordon, whose sincerity cannot be challenged, was persuaded by his emotional involvement with the mother's considerable problems and anxieties and his strong personal views in favour of sterilisation to form a less than detached opinion...” (p 192)

²⁴ “I think it was a pity that both Dr. Gordon and the mother were so reluctant to accept [other forms of contraception] and even the alternative of abortion, if, unhappily, it ever proved necessary, rather than the proposed use of such an irrevocable procedure.” At p195. Of course abortion itself is loaded with all sorts of moral and ethical controversies, but seemingly these are of lesser importance than the need to avoid sterilisation on social grounds.

²⁵ *Re M(A Minor)(Wardship: Sterilisation)* [1988] 2 FLR 497

uncomfortable for her and would have to be done under anaesthetic, whereby blood would be taken from the foetus by means of uterine puncture and tested in that way. So if the foetus was – and it was a 50% chance – diseased, then an abortion would have to be carried out. It is that risk that one is entitled to look at so far as the ward is concerned, and to say that this adds to the danger of her becoming pregnant.”²⁶

This is a eugenic argument! If there was true blindness to the issue of whether any child born would be disabled, then the question of testing for disability, and abortion if found, would not arise. Does this suggest that judges are in reality pursuing precisely those social goals which they purport to condemn?

A wider view of the cases suggests not. The otherwise universal thrust of the judgments is a vigorous denial of social considerations, as exemplified in *Re X*,²⁷ although the facts rarely demand such overt expression of it. In truth, Bush J’s apparently eugenic argument *is* a manipulation, not of the court’s purpose, but rather of the best interests test.²⁸ It demonstrates how the articulation of best interests can become an exercise in justifying, rather than finding, the judicially preferred outcome; and the preference is to avoid any suggestion of eugenics.

²⁶ At p499.

²⁷ “..there may or may not be a theoretically increased risk that if X were to give birth to a baby, that baby in turn might have impaired mental or intellectual capacity. I stress that that risk does not form any part of the motivation of X’s parents in making the present application, nor does it form any part of my reasoning in deciding to grant the proposed declaration. Many people now live good, fulfilling and rewarding lives in our society, despite impairment, of whom X is herself a very good example. The purpose of the proposed sterilisation has nothing at all to do with preventing possible birth of a possibly mentally impaired baby.” Holman J at p431

²⁸ Numerous other factors in the case pointed in favour of sterilisation, but Dr. Goldthorp – a major part of, but not the only, medical evidence – was vulnerable to the allegation that he had changed his mind to favour sterilisation only after it became apparent that there was a high risk of disability in any child conceived. If the judicial decision was to be immune from such allegations, the relevant part of Dr. Goldthorp’s evidence had to be explained in terms of M’s best interests.

These “special features” are the justification²⁹ for court intervention, as determined by *Re F*, and as such they inform court decisions. The court is not asked to authorise or legitimate medical actions which would otherwise be unlawful, but to provide a protective “third opinion” on the best interests of the patient. So, alien though these special features are to the majority of medical interventions, they have shaped the concept by which they too are decided. Caution in the face of reproductive rights has led to protectionism; fear of irreversibility has led to preference for minimal, reactive intervention; and avoidance of social engineering has led to emphatic individualism. Best interests latterly came to “encompass medical, emotional and all other welfare issues,”³⁰ but only as filtered, from the outset, through the triple lens of protectionism, reactivism and individualism.

The *process* by which the court identifies ‘best interests’ in sterilisation cases is now clearly established, and was neatly summarized in *Re X*.³¹

“...I need to consider, first, the degree of risk or likelihood of X becoming pregnant, if there is no form of contraception. ... Secondly, the risk of physical or psychological harm to X if she does become pregnant or give birth to a child....Thirdly, the range of possible alternative methods of contraception and the risks associated with them or whether there is any acceptable but reversible or less invasive alternative to sterilisation.”

The first two steps address protectionist considerations, and the third the requirement for minimal intervention. The whole process is conducted from individualist considerations, as is demonstrated by the fact that the locus of best interests across all the cases fall into just three broad categories: rejection of

²⁹ Lord Donaldson says (in *Re F* at p19) that *Re D* illustrates the need for court review: “no one cast the slightest doubt on the skill, bona fides or caring disposition of those who recommended and would have carried out the operation. They were simply blinkered to the possibility that they may be wrong.” But potentially the same may be said of all medical interventions. Mostly (for reasons of economy?convenience?) the system is prepared to live with that; only by reason of its special features are we not prepared to do the same with sterilisation.

³⁰ Per Butler-Sloss P in *Re A (Male Sterilisation)* [2000] 1 FLR 549 at p555.

³¹ *Re X (Adult patient: Sterilisation)* [1999] 3 FCR 426 at p428

social policy considerations,³² protection from pain and vulnerability,³³ and minimization of disadvantages of disability/maximization of freedom.³⁴

This leads to the ironic conclusion that the better carers are at looking after their mentally incapacitated charge, the less likely the court is to support them. The case of *Re S (Adult: Sterilisation)*³⁵ vividly demonstrated the point:

S was 22, attractive but mentally incapacitated, and vulnerable to sexual exploitation. Nothing untoward had happened to date, but her parents feared for her future and sought to eliminate any risk of pregnancy by sterilization. Johnson J found that there was no identifiable occasion when S had been at risk or would be in the future, and refused a declaration that sterilization would be in S's best interests.

Johnson J was reluctant to go against the parents' wishes, noting that the irony that "if a young woman is being cared for and supervised by caring and responsible parents, then the wish of the parents is to be overridden; whereas a similar decision will be upheld if made by parents who are careless and irresponsible,"³⁶ but he felt constrained to do so in the interests of identifiable consistency in court decisions. Johnson J's concern was that, if sterilisation were to be lawful in a situation of minimal risk, then it would be difficult to conceive of any factual situation where relief would be refused, so that the whole court procedure would become otiose – which would be wrong in principle.³⁷

³² *Re D*

³³ *Re B, Re M, Re P, Re ZM, Re X, Re W*

³⁴ *Re X, Re M, Re A* (if it had been fully argued)

³⁵ [1999] 1 FCR 277. See also *Re LC (Medical Treatment: Sterilisation)* [1997] 2 FLR 258, which was factually different in that L was cared for in a residential home, with paid staff round the clock. Although L had previously been sexually abused in care, the court was now convinced that the care provided to her was so good that any future risk was negligible, and in any event less than the risk inherent in the proposed surgery.

³⁶ At page 282

³⁷ "Whatever may be the appeal of a particular set of circumstances, the principle must be maintained that this form of medical procedure should never be carried out upon a woman incapable of giving her consent unless there has been the prior approval of a High Court judge that the procedure is in the light of all the circumstances one which is in the best interests of the woman." p 283

This is self-justification by the courts, at the expense of any consideration of what is practically required to keep the risk to the patient negligible. There are platitudes about how caring and responsible S's parents were, but no serious attempt to engage with them about the practical demands of this caring responsibility, to assess whether this would or could continue; and no practical support for the excellent job they were doing.

Third Party Interests: In truth there is another special feature of the sterilisation cases, which has not attracted judicial consideration, namely that third party interests are obviously affected. Where pregnancy is not prevented, there may be a child. Since that child is not yet in existence when the court is asked to consider sterilization, its potential interests have no legal standing,³⁸ but the possibility of a birth has implications for others. Where the sterilisation under consideration is of a woman, her wider family may be called upon to care for the baby;³⁹ and where the sterilisation under consideration is of a man, pregnancy would be have a very clear effect on any woman he may impregnate.

In *Re A*, the only reported case to consider sterilisation of a man, the question of third party interests was specifically left open by the Court of Appeal.⁴⁰ Whilst happy to accept that the best interests of a patient encompass interests as wide as “cultural, familial, spiritual and other”, Butler-Sloss P was somewhat grudging when it came to even the potential of third party interests,⁴¹ but Thorpe LJ seems more enthusiastic, preserving the argument in the very first paragraph of his judgment. It is perhaps surprising that the door which was carefully left ajar has

³⁸ See *Attorney-General's Reference (No. 3 of 1994)* [1998] AC 245; and *St George's Healthcare NHS Trust v. S* [1998] 2 FLR 728.

³⁹ As was expressly considered in *Re P (A Minor)(Wardship: Sterilisation)* [1989] 1 FLR 182, where the potential grandmother changed her evidence to the effect that she would raise any child born to P, rather than allow it to be adopted, but on the basis that P would have to live elsewhere. Living away from her mother would have implications for P's best interests which Eastham J was happy to take into account.

⁴⁰ [2000] 1 FLR 549, per Butler-Sloss P at p 556, and Thorpe LJ at p558.

⁴¹ “[Mother's Counsel] mounted an argument in his skeleton argument that the judge was wrong to ignore the effect on ‘third party interests’ (eg the child and/or the young woman). It was only briefly pursued in oral argument. On the facts of this case, that argument is not well-founded.....I agree however with Thorpe LJ that the question whether third party interests should ever be considered in a case concerned with the best interests of a patient ought to be left open”, at p 556.

not been pushed at since: there are no reported cases where third party interests have been specifically argued.

Carers' interests are obvious in those sterilization cases where the driving issue is not fear of pregnancy, but fear of menstruation.⁴² Coping with menstrual bleeding is an unpleasant task for the carers (in the reported cases, all of whom are family members) of a mentally incompetent woman, and it is experienced as an additional, biologically pointless burden, coming just at a time when care is becoming more difficult anyway simply by virtue of the patient's increasing size. It would not seem unreasonable if the family preference is for those forms of intervention which end menstruation totally, rather than lessen it. However, this kind of third party interest is perceived by the court as one of "carer's convenience,"⁴³ and dismissed accordingly, however extreme the practical demands.

Yet, where there is strong evidence that menstrual bleeding causes the patient herself distress, the courts have no difficulty in sanctioning even hysterectomy, the most invasive form of sterilization. Unsurprisingly, the presentation of cases in court is shaped by this awareness. In *Re GF*,⁴⁴ the case was considered on a strictly therapeutic basis only, and a declaration was said to be unnecessary (but would have been granted had it been needed). In *Re ZM & OS*,⁴⁵ the medical evidence of heavy, painful and irregular bleeding, was graphically supported by evidence from Z's mother and sister (from which it is easy to surmise the impact on family life, although the evidence is never framed from that perspective). A declaration in favour of hysterectomy was granted, even against the submissions of the Official Solicitor.

⁴² *Re GF (Medical Treatment)* [1992] 1 FLR 293; *Re ZM & OS (Sterilisation: Patient's Best Interests)* [2001] 1 FLR 523; *Re S (Adult Patient: Sterilisation)* [2001] 1 Fam 15

⁴³ To paraphrase Lord Jauncey, in *Re F* at p83.

⁴⁴ *Re GF (Medical Treatment)* [1992] 1 FLR 293. The case set out the criteria for carrying out sterilization without court approval: that two medical practitioners are satisfied that it is necessary for therapeutic purposes, is in the best interests of the patient and there is no practicable, less intrusive means of treating the condition.

⁴⁵ [2000] 1 FLR 523, Bennett J.

In marked contrast, in *Re S (Adult Patient: Sterilisation)*⁴⁶ the Court of Appeal was very critical of Wall J for attaching disproportionate weight to the evidence of the family,⁴⁷ who favoured hysterectomy, against medical evidence which favoured the less invasive Mirena coil, at least to begin with. The higher court refused to sanction sterilisation.

The contrasting outcomes of *Re ZM* and *Re S* demonstrate a rigidly individualistic approach to best interests. The descriptions by the families of the practical realities of menstruation are markedly similar; and both women experienced pain and distress. The declaration was granted in *Re ZM* because there was medical evidence that blood flow was “abnormal”, so medical intervention would be therapeutic; and refused in *Re S* because it wasn’t, so intervention would simply be a matter of convenience. Convenience is too close to eugenics for comfort.

Yet recognition of the caring burden need not be seen as the first step on a slippery slope to eugenics. Cases seeking judicial approval of sterilisation to alleviate the burden of menstruation are not brought by the state, but by individuals and families. They are not a device for social engineering, but a plea for help in coping with difficult circumstances. A sympathetic judgment will not mean that courts are inundated with similar claims because, fortunately, significant mental disability in pre-pubescent girls is factually rare, and its implications different in every case. There are no floodgates in individuality.

Would the outcome of *Re S* have been different if her mother had said that the practical difficulties of dealing with her menstruation were so overwhelming that she could no longer continue to provide care?⁴⁸ A plausible argument could then

⁴⁶ [2001] Fam 15

⁴⁷ Per Butler-Sloss P at p 25. “The understandable concerns of a caring mother and the problems of dealing with S during her menstrual periods do not, on the facts of this case, tilt the balance towards major irreversible surgery for therapeutic reasons when they are unsupported by any gynaecological, psychological or other medical evidence.”

⁴⁸ Such a ploy may be objectionable as emotional blackmail, but it is amply demonstrated in the context of consent to blood testing for paternity (see later). Moreover there is clear indication that the court would be swayed by such an argument in the comment of Hollis J in *Re W (An Adult: Sterilisation)* [1993] 3 FCR 426t: “If worry affected the mother, then it would be likely

have been constructed that hysterectomy was in S's best interests because of her emotional and psychological need to remain living at home. The evidential lacuna before Wall J would be thereby filled, and the court could grant the declaration.

When the concept of best interests is so obviously malleable, it is not difficult to see how a well-advised family could squeeze their arguments into the narrow mould of patient-centred considerations to which the court gives weight, should they be so determined. Indeed, exactly that process can be seen when looking at decided cases chronologically,⁴⁹ and it may be an inevitable implication of the common law method of argument. However it militates against an open consideration of the true basis for medical intervention, and suggests suspicion of family motives where there need be none. How much more honest, and more open to scrutiny the process would be if it simply made space for families to present their views and interests as a legitimate consideration for the court – a possibility which *Re A* leaves open.

Conclusions: As a medical procedure sterilisation has special features which informed the inherent jurisdiction and the understanding of 'best interests' from its very invention. The court's aversion to eugenic sterilisation amounts to a deontological principle which ensured that the court's jurisdiction was launched with a protectionist, reactive, and above all *individualistic* interpretation of best interests. The effect has been to constrict considerations of a patient's interests into narrow channels which overlook genuine individual interests in family care, and deny those families the recognition which their efforts and self-sacrifice deserve.

that that would affect her care of W. This is not a factor that has been dwelt upon by Counsel before me, but it is nevertheless a factor that I take into account."

⁴⁹ For example, Heilbron J regretted the family's failure to consider less intrusive alternatives to sterilisation in *Re D*; so the next time similar issues came to be argued before court (in *Re B*) we see the calling of evidence to exclude all lesser forms of contraception as ineffective and the birth process as disastrous. The pattern continues along the timeline of cases. For overview, see appendix 1.

B. Life saving treatment

Sometimes medical treatment can hold the balance between life and death; sometimes it is not clear which may be preferable. Usually the patient herself is in no position to express a preference. In tragic circumstances which are fraught with moral ambiguity, the court may be asked to adjudicate on the continuation or termination of treatment. At the root of any decision are values much more profound than the strictly legal. The life-or-death consequences demand that the familiar guide of “best interests” is interpreted according to much more fundamental concepts than usually disturb judicial equanimity.⁵⁰

The Importance of Chance: From the earliest authority, it has been apparent that *whose* view of “best interests” ultimately prevails will depend in the first instance on chance – the *chance* of disagreement in the treating hospital:

*Re B (A Minor)(Wardship: Medical Treatment)*⁵¹ : A baby girl, B, was born with Down’s Syndrome and an intestinal blockage. The blockage would lead to her death within days if untreated, but relatively minor surgery was likely to secure for her the full Down’s Syndrome life expectancy of 20 -30 years.

(a) The parents refused consent to the operation, taking the view that it was kinder to let her die.

(b) The doctors referred the matter to the Local Authority who applied *ex parte* to make B a ward of court. Ewbank J granted the applications and directed that the operation be performed.

⁵⁰ “These cases evoke some of the fundamental principles that undergird our humanity. They are not to be found in Acts of Parliament or decisions of the courts but in the deep recesses of the common psyche of humanity whether they be attributed to humanity being created in the image of God or whether it be simply a self-defining ethic of a generally acknowledged humanism.” Per Hedley J in *Portsmouth NHS Trust v. Wyatt* [2004] EWHC 2247 at para 21.

⁵¹ [1981] 1 WLR 1421

(c) B was then moved to a different hospital where the surgeon (Z) declined to operate when he learned of the parents' views. The matter went back before Ewbank J who revoked the order.

(d) The parents were then served with the legal proceedings and made representations. Enquiries identified two surgeons who were prepared to operate, but Ewbank J concluded that the parents' wishes ought to be respected.

(e) The appeal against that decision was heard later the same day. The Court of Appeal concluded that the operation would be in B's best interests.

If B had happened to have been born in Surgeon Z's hospital,⁵² the case would never have come before the courts, the blockage would not have been treated, and B would have died. Everybody accepted that the parents' decision was an "entirely responsible one, doing what they considered best."⁵³ Yet by chance disagreement, their decision was challenged and ultimately overridden; the blockage *was* treated, and B lived.

For B's mother and father, the decision not to consent to surgery was the first expression of their parental responsibility. The judges' only direct explanation for disregarding it was the "shock" they must be feeling from the birth of a disabled child.⁵⁴ Of course that was not the true reason behind the Court of Appeal's decision. Chance having put the case before the court, it was determined according to law. B then being a ward of court, the court's "first and

⁵² Or indeed, most hospitals: Surgeon Z believed that the same decision as his "would be taken by the great majority of surgeons faced with a similar situation." (Quoted by Templeman LJ at p1423.)

⁵³ Per Dunn LJ at p1424.

⁵⁴ "The shock to caring parents finding that they have given birth to a child who is a mongol is very great indeed, and therefore while great weight ought to be given to the views of the parents they are not views which must necessarily prevail." Per Templeman LJ at p 1422. "Therefore" implies "because" they are in shock. So a view considered over time should be weighed differently?

paramount” consideration had to be the interests of the child.⁵⁵ On the question of what was “best” for the child, the Court of Appeal simply disagreed with parents.

The First Judicial Preference - Life Over Death: The disagreement turned on assessment of the value of a life lived with Down’s Syndrome.⁵⁶ As the parents saw it, the intestinal blockage was “God or nature giv[ing] the child a way out”⁵⁷ of a life of severe mental and physical handicap. The Court of Appeal (and Ewbank J before he heard from the parents) saw it differently: medical science should prevail over God or nature unless the life thereby preserved “is demonstrably going to be so awful that in effect the child must be condemned to die.”⁵⁸ If B’s life was still imponderable, failure to preserve it would be wrong. *Ergo*, the parents’ view was wrong.

But was B’s life – or life with B in it - really imponderable? Reading the decision of the court suggests instead that it was simply ‘not pondered’. There was absolutely no express consideration by the Court of Appeal of how B’s life would in fact be led. B was now a ward of court. Who would bring her up? With their wishes about her very existence overridden, would the parents accept the burden of parenting a disabled child for her entire life? The Local Authority had applied to free B for adoption, so substitute parents would have to be found. What would be the prospects of finding adoptive parents for a severely handicapped baby? If the search failed, how would she fare in long-term care? None of these questions were addressed by the court. It is of course possible that the parental views would still have been considered “wrong” if these questions had been asked, but the failure to ask them shows that the judicial preference is solely one of principle: life over death except *in extremis*.

⁵⁵ As Dunn LJ put it at p1424, the court “cannot hide behind the decision of the parents or the decisions of the doctors; and in making the decision this court’s first and paramount consideration is the welfare of this unhappy little baby.” Or per Templeman LJ at p 1424: “The judge was much affected by the reasons given by the parents and came to the conclusion that their wishes ought to be respected. In my judgment he erred in that the duty of the court is to decide whether it is in the interests of the child that an operation should take place.”

⁵⁶ The positive aspects of which are probably clearer today than they were when the case was decided in 1981.

⁵⁷ As quoted by Dunn LJ at p1424

⁵⁸ Per Templeman LJ at p 1424.

A Rebuttable Preference - Judicial Balancing: One of the difficulties of such an approach is finding an acceptable formulation of the extreme situation which justifies deviation from the general thrust of principle. If medical treatment is not intended to prolong life, then what is its purpose? Life being what it is, it was not long before a case came before the courts posing exactly that question. When Ward J in *Re C (A Minor)(Wardship: Medical Treatment)*⁵⁹ granted medics permission “to treat the minor [patient] to die”, he fuelled anxieties that any approach short of prolonging life at any cost was the start of the slippery slope towards euthanasia.⁶⁰

The phrase was used in an ex tempore judgment, and Ward J himself had quickly amended the phraseology of the order to sanction instead “treat[ing] the minor to allow her life to come to an end peacefully and with dignity”. Yet, however euphemistically the order was worded, the substance of the judgment remained, and it demonstrated that the judicial concept of best interests could countenance death as the preferred option.

Such a view demands clarification, and the Official Solicitor led the exploration at the next available opportunity. In the case of *Re J*,⁶¹ a baby was born prematurely and suffered severe brain damage. He was unlikely to develop even limited intellectual abilities but was probably able to feel pain. His most optimistic life expectancy was late teens. The hospital sought leave to follow a course of treatment which would not require him to be ventilated. When the judge granted the application, the Official Solicitor appealed. He made two submissions: first, the absolutist one that the court should never withhold consent to treatment which may allow survival; and secondly, the qualified one, that consent could be withheld, if the quality of life anticipated after treatment

⁵⁹ [1990] Fam 26. C was born with severe and irreversible brain damage. The Local Authority applied to court for a declaration that she should be treated in accordance with a specialist report which recommended that the objective of treatment should be to ease suffering rather than prolong life.

⁶⁰ One of the objectives of the Official Solicitor’s appeal was to test exactly that, and the Court of Appeal supported his pursuit of it: “Third, the Official Solicitor wished to allay anxieties in some quarters that the hospital staff were treating C in a way designed to bring about her death...The Official Solicitor has been quite right to adopt this course.” Per Lord Donaldson at p36.

⁶¹ [1991] Fam 33

would be intolerable.⁶² The Official Solicitor therefore forced the court to state its position on treatment as life preservation.

The parents did not take a view⁶³ so, despite Lord Donaldson's emphasis on a multi-party approach,⁶⁴ the decision was taken on medical and legal instincts alone. The court clearly rejected the absolutist submission, and thereby an approach to best interests which valued life above all else. Whilst recognising a very strong presumption in favour of prolonging life, it was said to be rebuttable. Morally, this is a significant step, and the court was keen that it should not be exaggerated: the door was firmly closed to euthanasia, by distinguishing between the imposition of death, and choosing a course of action which would fail to avert death.⁶⁵

But though the Official Solicitor's absolutist rejection was clearly rejected, his qualified submission was not clearly adopted. "Intolerability" was rejected as a quasi-statutory yardstick.⁶⁶ It was to raise its head again later, but for now it was retained as a descriptive term only, with a new emphasis on its subjectivity,⁶⁷ seeing it from the patient's point of view. The implicit balancing exercise was embraced.⁶⁸ On one end of the seesaw goes the strong presumption in favour of life; but on the other end there must be consideration of "the pain and suffering and quality of life" if it continues, and "the pain and suffering involved in the

⁶² This submission is clearly based on the judgment of Templeman LJ in *Re B*.

⁶³ Per Taylor LJ at p 53: "In the present case the parents, finding themselves in a hideous dilemma, have not taken a strong view..."

⁶⁴ At p41.

⁶⁵ Per Lord Donaldson at p44: "What is in issue...is not a right to impose death, but a right to choose a course of action which will fail to avert death."

⁶⁶ Per Lord Donaldson at p 47; per Balcombe J at 52

⁶⁷ per Taylor LJ at p55: "the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. I must say "to that child" because the test should not be whether the life would be intolerable to the decider. The test must be whether the child in question, if capable of exercising sound judgment, would consider the life intolerable." Lord Donaldson adopted at p47 the formulation of Justice Asche in *Re Weberlist* (1974) 360 NYS 2d783 at 787: "the decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person..."

⁶⁸ "*Re B* seems to me to come very near to being a binding authority for the proposition that there is a balancing exercise to be performed in assessing the course to be adopted in the best interests of the child. Even if it is not, I have no doubt that this should be and is the law." Per Lord Donaldson at p 46.

proposed treatment itself.”⁶⁹ However, the pivotal point of the seesaw was deliberately undefined:⁷⁰ each case must be considered as if in isolation – the anti-thesis of casuistry.

This noble-sounding approach is in fact little more than a smokescreen for unfettered judicial discretion. In the case of a child like J, the view of the patient can never be known or even guessed at for the simple reason that his fate – the very fate which brought the matter to court – was that he had never been and would never be able to form a view. To ascribe one to him is mere supposition, saying more about the views and imagination of the decision-maker than about J. Rejecting casuistry, and without any principle to guide assessments of best interests in the context of prolonging life or standing by for death, all the court can offer is an ethic of virtue or care, yet the individualistic and subjective interpretation of best interests by the Court of Appeal in *Re J* disavows both. At this point, the law has assumed authority to decide matters of enormous significance, but left its judges floundering in a jurisprudential vacuum.

Avoiding the Preference – When Life has Gone Already: The logical difficulties inherent in a ‘balancing’ approach based in neither principle nor ethic become all too obvious when the patient in question suffers even worse disability than J, but less cognisance of it – the tragedy of the patient in a persistent vegetative state, for whom all function, but also all sentience, is lost.⁷¹ What are the factors to balance against the sanctity of life, when the patient has no awareness of whether he lives or dies?

In *Airedale NHS Trust v. Bland*⁷² nine judges were unanimous in their decision that the principle of sanctity of life should not prevail, but at variance in their methodology and reasoning. In particular, although all accepted the propriety of declaratory proceedings on the *Re F* model, the understanding of the best interests test differed markedly.

⁶⁹ Per Lord Donaldson at p 46. See also Taylor LJ at p55.

⁷⁰ Per Balcombe J at p 52: “I would deprecate any attempt by this court to lay down such an all-embracing test since the circumstances of these tragic cases are so infinitely various.”

⁷¹ As Lord Goff described it at p 863, “a living death”.

⁷² [1993] 2 WLR 316

The issue was lawfulness of withdrawal of treatment which Anthony Bland had been receiving for three years, in the certain knowledge that death would follow soon after. This is significantly different to that in *Re J*, which was a prospective one of permission never to embark on a course of treatment in the first place. However it is phrased, the Bland scenario takes doctors one step closer to euthanasia,⁷³ and public anxiety ran high.⁷⁴ The need to be clear about the court's function and power was acute.

At first instance, Sir Stephen Brown P was satisfied that treatment conferred "no therapeutic, medical or other benefit" to the patient, and its discontinuance would be in accordance with good medical practice. *Therefore* withdrawal of treatment was in Anthony Bland's best interests.⁷⁵ The agreement of the family to the proposed withdrawal was of some, albeit unexplained, importance. The President was performing the balancing exercise, simply putting at each end of the seesaw whatever factors seemed significant to him and declaring that those factors in favour of discontinuance weighed more heavily.

⁷³ Certainly for many people the court's distinction between active agency to bring about death, and removing artificial support for life so that death supervenes (per Lord Browne-Wilkinson at p802), was a distinction without difference. Much commentary has been written about the validity of the distinction (see for example J.M. Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 LQR 329, and J. Keown, 'Restoring Moral and Intellectual Shape to the Law after Bland' (1997) 113 LQR 481. Andrew McGee in 'Finding a Way through the Ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia' (1995) MLR 357 at 383 offers a supportive explanation of the distinction: "What is proposed in euthanasia is that *we* wrest from nature control of our ultimate fate: we decide when and how we should die, and we ensure that we have the last word. In lawful withdrawal, by contrast, the very opposite is the case: we interfere with nature, not in killing the patient, but *in keeping the patient alive*, and the question of whether or not we should withdraw treatment is at bottom the question of whether we should restore to nature her dominion, allowing nature finally to take its course, with the patient dying a natural death. In short, the moral relevance of the distinction can therefore be put in this way: *euthanasia interferes with nature's dominion*, whereas withdrawal of treatment *restores* to nature her dominion after we had taken it away when *artificially* prolonging the patient's life."

⁷⁴ As Hoffman LJ put it at p825, "People are worried, perhaps not so much about this particular case, but about where it may lead. Is the court to assume the role of God and decide who should live and who should die?"

⁷⁵ At p805

In the Court of Appeal, the judgements examined more critically the concept of best interest. Mere existence was not considered a benefit,⁷⁶ but much wider considerations than simply the physical were embraced:

Sir Thomas Bingham MR gave weight to “the constant invasions and humiliations to which his inert body is subject;...the desire he would naturally have to be remembered as a cheerful, carefree, gregarious teenager and not an object of pity; to the prolonged ordeal imposed on all members of his family, but particularly on his parents; even, perhaps....a belief that finite resources are better devoted to enhancing life than simply averting death.”⁷⁷

Butler-Sloss LJ included “some degree of monitoring of the medical decision”⁷⁸ and a respect for continuing humanity.⁷⁹

Hoffmann LJ included “personal privacy and dignity.”⁸⁰

They too carried out the balancing exercise, and decided that the patient’s interests in withdrawal outweighed the abstract requirement to preserve life.⁸¹ The stark choice between sanctity and quality of life was acknowledged,⁸² and made. This approach clearly encompasses an ethic of care: the concept of “best interests” is stretched wide enough to include consideration of the impact on others of a proposed course of treatment. The ordeal which the treatment represented to his family was a factor which added weight to the discontinuance end of the seesaw. To that extent it is a refinement of the simple balancing exercise, and one which recognises interests other than the patient’s.

⁷⁶ Per *Sir Thomas Bingham MR* at p 813: “‘I cannot conceive what benefit his continued existence could be thought to give him.’”

⁷⁷ At p813.

⁷⁸ At p 819

⁷⁹ At p820: “To limit the quality of life [balancing factors] to extreme pain is to take a demeaning view of a human being. There must be something more for the humanity of the person of a P.V.S. patient. He remains a person and not an object of concern.” Further, at p 822 “..he has a right to avoid unnecessary humiliation and degrading invasion of his body for no good purpose.”

⁸⁰ At p829

⁸¹ Per *Butler-Sloss LJ* at p823.

⁸² *Hoffman LJ* at p830 rejected the *Amicus*’ argument that there was no conflict between them because the principle of sanctity of life could be understood as embracing a need for respect for dignity etc. To his mind this was “rhetoric intended to dull the pain of having to choose.”

However, the House of Lords took a different approach. Clinical value of treatment was emphasised over best interests, simultaneously reducing thereby both the principle of sanctity of life and the breadth of best interest considerations:

(a) *Lord Goff* considered that treatment had no therapeutic benefit, and could therefore be properly regarded as medically useless. Sanctity of life not being an absolute principle, the futility of treatment justified its discontinuation, and no balancing act had to be performed.⁸³

(b) *Lord Keith* specifically doubted that best interest could be said to favour discontinuance, on the basis that an insensate patient was completely indifferent to whether he lived or died.⁸⁴ Holding the view that mere existence was not a benefit,⁸⁵ and that the principle of sanctity of life was not absolute, a doctor was under no duty to provide treatment which conferred no benefit, and therefore withdrawal was lawful.

(c) *Lord Browne-Wilkinson* redefined the legal question to one of reasonableness of medical opinion.⁸⁶ Since the doctors took the view

⁸³ At p 869: "...there is in reality no weighing operation to be performed. Here the condition of the patient, who is totally unconscious and in whose condition there is no prospect of improvement, is such that life-prolonging treatment is properly regarded as being, in medical terms, useless.....I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life, when such treatment has no therapeutic purpose of any kind....it is the futility of treatment which justifies its termination."

⁸⁴ At p 858.

⁸⁵ At p859

⁸⁶ At p 884: "...the legal question in this case ..is not whether the court thinks it is in the best interests of Anthony Bland to continue to receive intrusive medical care but whether the responsible doctor has reached a reasonable and bona fide belief that it is not.....the court's only concern will be to be satisfied that the doctor's decision to discontinue is in accordance with a respectable body of medical opinion and that it is reasonable." Eminent though he is, Lord Brown-Wilkinson's view must be limited to the narrow facts of this case. The *Bolam* test is concerned with standards of care, and must have limited scope in cases where the issue before the court is whether treatment, or its withdrawal, is in the best interests of the patient. See for example comments of the Court of Appeal in *An NHS Trust v. X* [2005] EWCA Civ 1145 at paras 94-95.

that there was no benefit in staying alive, and discontinuance satisfied the Bolam test, it would be unlawful to continue treatment.

(d) *Lord Mustill* rejected the idea that the patient had any interest at all in continuation or termination of life;⁸⁷ that being so, the justification for treatment without his consent disappeared, taking with it any duty to continue it.⁸⁸

Avoiding avoidance: Where does this leave the judicial concept of best interests? A majority of the Law Lords purported to agree with the Court of Appeal and for the same reasons,⁸⁹ which should be authoritative support for the refined balancing exercise and a broad interpretation of best interests. However two Lords specifically rejected such a view;⁹⁰ and they all adopted a decision mechanism which avoids court assessment of best interests altogether. The import of the House of Lords judgment in *Bland* is that when the patient has no *medical* interests, there is no balancing act to perform – which significantly undermines the Court of Appeal approach.

It is possible to reconcile the judgments of the higher courts, by limiting the House of Lords' approach to the specific medical facts. Whereas it would be logically possible to apply the Court of Appeal's concept of best interests to other medical scenarios,⁹¹ the same cannot be said of the House of Lords

⁸⁷ At p 897: "He feels no pain or anguish.....it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow....The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland for he has no best interests of any kind."

⁸⁸ At p 897: "Thus although the termination of his life is not in the best interests of Anthony Bland, his best interests in being kept alive have also disappeared, taking with them the justification for the non-consensual regime and the co-relative duty to keep it in being."

⁸⁹ Per Lord Goff at p 863. The others then agree with Lord Goff – Lord Keith at p 859, Lord Lowry at p875 .

⁹⁰ Lord Browne-Wilkinson at p884 by redefining the question, and Lord Mustill at p897 in the forthright words quoted at n37 above.

⁹¹ The final position of the seesaw may be different if, for example, family/society's suffering in continuation of treatment was counter-balanced by pain of the patient in discontinuing it, but the very exercising of balancing factors provides exactly the mechanism whereby different interests *can* be considered.

approach. It only works in a situation of complete lack of sentence.⁹² For this reason, it is at least arguable then that the approach of the higher court does *not* overrule the broad view of best interests adopted by the Court of Appeal, for use in less extreme medical conditions, with implications obviously to the benefit to families.

The lower courts were certainly less than impressed with the approach of the House of Lords, and simply did not follow it. The abandonment of the best interests test was felt to cede too much power to medics. (Indeed Lord Browne-Wilkinson's formulation of the legal question would require only that the clinical preference accords with a body of good practice for it to be determinative.⁹³) Sir Thomas Bingham MR articulates such a reply to their Lordships as soon as the Court of Appeal next had the opportunity, in *Frenchay Healthcare NHS Trust v. S*,⁹⁴ where again the patient was in a persistent vegetative state, and the Court of Appeal was keen to scrutinise medical judgment.

A significant difference of approach between tiers of court is revealed. The lower courts, who are accustomed to dealing in facts, see court involvement – court *determination* – as a desirable practice, offering protection to patients, doctors, families and the public⁹⁵ (seemingly, in that order of priority). On the other hand, the House of Lords, a court of principle, is prepared to countenance this as a short term approach of necessity only.

Lord Goff was practically motivated: he was impressed by the care being taken by the BMA's Medical Ethics Committee to provide guidance to the profession, and concerned by the cost burden of reference to court. He wanted only cases of

⁹² As was impliedly recognised by Lord Mustill at p899: "This is not at all to say that I would reach the same conclusions in less extreme cases, where the glimmerings of awareness may give the patient an interest which cannot be regarded as null."

⁹³ It is to be noted that Lord Mustill at p898 specifically doubted the validity of the Bolam test in this area of determination

⁹⁴ [1994] 1 WLR 601 at p 609: "It is, I think, important that there should not be a belief that what the doctor says is in the patient's best interests is in the patient's best interests. For my part I would certainly reserve to the court the ultimate power and duty to review the doctor's decision in the light of all the facts." On the other hand, although Bingham MR quotes the Consultant referring to the views of the patient's mother (at p 605), he actually makes no direct reference to family views in this case.

⁹⁵ See Bingham MR at p815-816

special need to invoke court procedure.⁹⁶ Lord Mustill, however, was deeply uncomfortable about the use of this court procedure at all. He spends over three pages of the law report⁹⁷ explaining the reasons for his discomfort, but foremost amongst them is acknowledged lack of authority in matters which are moral, rather than legal:

“If the criteria for the legitimacy of the proposed conduct are essentially factual, a decision upon them is one which the court is well accustomed to perform, and may properly be obtained through the medium of an application for declaratory relief. If however they contain an element of ethical judgment, for example if the law requires the decision-maker to consider whether a certain course is ‘in the best interests’ of the patient, the skill and experience of the judge will carry him only so far. They will help him to clear the ground by marshalling the considerations which are said to be relevant, eliminating errors of logic, and so on. But when the intellectual part of the task is complete and the decision-maker has to choose the factors which he will take into account, attach relevant weights to them and then strike a balance the judge is no better equipped, though no worse, than anyone else. In the end it is a matter of personal choice, dictated by his or her background, upbringing, education, convictions and temperament. Legal expertise gives no special advantage here.”⁹⁸

By implication, the lower courts rejected such squeamishness. Although their assertion of judicial determination was framed as a check on medical professionals, its operation is universal – so it excludes family influence too. Paradoxically, Lord Mustill’s speech could be read as a passionate expression in the House of Lords of the *family’s* claim to greater influence on the assessment of the best interests of their loved ones. Family members are in no less a position of authority than any other contenders for moral decision-making authority, and

⁹⁶ At p 874

⁹⁷ Pp 887-891

⁹⁸ At p 887-8

arguably their familiarity with and concern for the patient gives them an advantage. The only basis for court supremacy, therefore, should be one of protection of the patient, in comparatively rare instances of carer inadequacy, improper motivation or abuse of power. However, no such family-friendly interpretation occurred to the lower courts.

When just such a protective application came to court in *Re R (Adult: Medical Treatment)*,⁹⁹ the President simply distinguished *Bland* as factually different, and adopted instead the balancing exercise of *Re J*, as if their Lordships had never spoken.¹⁰⁰

The 23 year old patient had been born with serious brain damage and was now deteriorating neurologically and physically. The medics believed that CPR in the event of a life-threatening incident would be “nothing more than striving officiously to keep him alive for no gain to him”. The chances of success were almost nil, and the procedure carried some risk of injury. R’s parents supported the doctors’ view, but carers in his home were concerned and initiated court proceedings.

Sir Stephen Brown P adopted the best interests test of *Re J*, and held that the decision was fully within the consultant’s responsibility. The factual outcome of the case was consistent with the House of Lords in *Bland*, but the reasoning adopted was the Court of Appeal’s.

How far such reasoning could be stretched became apparent in the next case to be determined. In *Re Y (Mental Incapacity: Bone Marrow Transplant)*¹⁰¹ the life in need of preservation was that of an entirely competent woman with a six year old daughter and leukaemia. She urgently needed a bone marrow transplant. Of three possible donors identified, the one with the best prospect of success was her 25 year old severely handicapped sister, Y. Y had not lived with her family

⁹⁹ [1996] 2 FLR 99

¹⁰⁰ At p 107. The only quotations from the House of Lords in *Bland* are those at p 108-109, which refer to the desire to limit applications to court. The subsequent case of *A NHS Trust v. D* [2000] 2 FLR 677 maintained the same methodology too.

¹⁰¹ [1997] 2 FCR 172

since the age of 10, but their mother visited her regularly. Connell J decided that the donation procedure *would* be in Y's best interests.

The decision is remarkable in a number of respects. Connell J did not just widen the assessment of Y's interests to include factors other than the strictly medical; he went further, and actually downplayed the medical interests.¹⁰² Y's emotional, psychological and social interests in prolonging and improving relations with her family were said to outweigh medical ones, even though such interests were only vaguely identified.

At first blush Connell J's decision seems to be the very embodiment of what we are searching for – a willingness to recognise competing family interests in a medical treatment dispute. Feenan certainly sees the decision as 'signal[ling] a shift ...towards respecting the importance of relationship in determining best interests.'¹⁰³

On closer consideration, the case does not support such an analysis. In truth the benefit which Y actually derived from the relationships with either her mother or her sister was highly questionable. The evidence was that the sister visited her infrequently, and Y did not understand that her regular visitor was her 'mother'. There was no expert psychological opinion on what benefit Y actually did derive from visits, but the emotional bond of a child to her parent was clearly not a factor. Insofar as the judgment expressed respect for relationships, they were surprisingly tenuous relationships to favour.

The decision is better seen as the starkest illustration of the court's fundamental preference for life over death, and the susceptibility of the concept of 'best interests' to distorted interpretation in order to further that preference. A 40% chance of extending someone else's life by a further eighteen months simply

¹⁰² At p 178: "...the evidence shows that the bone marrow harvested is speedily regenerated and that a healthy individual can donate as much as two pints with no long term consequence at all. Thus the bone marrow donated...will cause her no harm and she will suffer no real long-term risk." And what of the short and medium term risks of surgical procedure? What of any psychological implications?

¹⁰³ In 'Case Commentary: A Good Harvest' [1997] CFLQ 305 at p305.

bought sufficient social and moral benefits to outweigh the disadvantages to a woman who could not understand the (not insignificant) procedures involved, even though there were two other potential (but less well matched) donors.¹⁰⁴ If Connell J's decision is questionable,¹⁰⁵ that is not because the factors he took into account were wrongly considered, but because they were wrongly weighed.

Beyond the First Preference: Set in this chronological context, the decision in *Re T (A Minor)(Wardship: Medical Treatment)*¹⁰⁶ is a natural development and a reasonable application of the reasoning of the Court of Appeal in *Bland*:

T was born with biliary atresia, a liver complaint. He had had unsuccessful surgery when a few weeks old, which caused pain and distress. The unanimous medical opinion was that a liver transplant would be in his best interests, and that without it he would die by the age of two and a half. However, the information sheet used to explain the procedure to patients and their families acknowledged the enormity of a transplant decision, and claimed to respect individual decisions.¹⁰⁷ T's parents, who were neonatal nurses now working outside the UK (in a country with no facilities for liver transplant), refused consent.¹⁰⁸ Another hospital, to which the family had been referred, respected that decision and would not operate against it.¹⁰⁹

¹⁰⁴ It is worth noting, as does Feenan, that the Convention for Protection of Human Rights and Dignity of Human Beings with Regard to the Application of Biology and Medicine, which was completed after the decision in *Re Y* prohibits removal of regenerative tissue from mentally incapacitated persons unless, inter alia, there is no compatible donor available who has capacity to consent (Art 20(2)(ii)).

¹⁰⁵ Connell J was himself anxious to limit the attachment of any wider significance to his decision. He said (at p178): "It is doubtful that this case would act as a useful precedent..."

¹⁰⁶ [1997] 1 All ER 906

¹⁰⁷ "It is a very big decision to make...If the family choose not to proceed with the transplantation once they are acquainted with the facts, the decision is respected." Quoted by Butler-Sloss LJ at p 245 and Roch LJ at p 256

¹⁰⁸ As her Counsel put the argument and summarised by Butler-Sloss LJ at p 248, "The choice was to allow the child a short life where he was well and happy for most of the time and would be likely to die peacefully or to cause him to undergo major invasive surgery with a good success rate but all the risks, discomfort and distress for a young child and a lifetime of drugs and the possibility of further invasive surgery and other treatment. The consequence of the treatment was to commit the mother to a lifetime of care of the child with the requirement of total commitment to the child. The importance of the element of morale was not to be underestimated."

¹⁰⁹ "Dr. P...formed the view that she was a loving and devoted mother, and from her professional background, an unusually well-informed parent. They concluded that her reluctance to submit her son to the operation was founded in love and care for him. She was to the best of her ability

The Local Authority invoked the inherent jurisdiction of the court, and Connell J ordered that the child be brought back to the UK for transplant assessment. The mother appealed, successfully. The Local Authority was refused the declaration it sought.

The Court of Appeal considered that Connell J had got the balancing act wrong: “he did not weigh in the balance reasons against the treatment which might be held by a reasonable parent *on much broader grounds* (italics added) than the clinical assessment of the likely success of the proposed treatment.”¹¹⁰ The approach of Butler-Sloss LJ is consistent with her understanding of best interests in *Bland* and expressly embraces an ethic of care:

“This mother and this child are one for the purpose of this unusual case and the decision of the court to consent to the operation jointly affects the mother and son and it also affects the father. The welfare of this child depends upon his mother. The practical considerations of her ability to cope with supporting the child in the face of her belief that this course is not right for him, the requirement to return probably for a long period to this country, either to leave the father behind and lose his support or to require him to give up his present job and seek one in England, were not put by the judge into the balance.”¹¹¹

However, the decision in *Re T* is usually dismissed as an aberration, explicable by the need to correct the error of the judge at first instance in deciding the case

discharging her duty of trust to the child and her decision should be respected.....Dr. P and his team, while strongly recommending the operation, would wish to respect the decision of the mother and would not be prepared to perform the operation without her consent.” Per Butler-Sloss LJ at p 246 & 247

¹¹⁰ Butler- Sloss LJ at p 250-251, reasons such as “deep-seated concern of the mother as to the benefits to her son of the major invasive surgery and post-operative treatment, the dangers of failure long-term as well as short-term, the possibility of the need for further transplants, the likely length of life, and the effect upon her son of all these concerns.” Moreover the judge did not consider “the evidence of Dr. P and his strong reservations to the effect of coercing, as Dr P put it, this mother into playing the crucial and irreplaceable part in the aftermath of major invasive surgery not just during the post-operative treatment of an 18 month old baby but also throughout the childhood of her son. ” This broader view of best interests is welcomed by Andrew Grubb in ‘Medical Treatment (Child): Parental refusal and the Role of the Court’ [1996] 4 Med L Rev 315-319 at 318

¹¹¹ P251

according to assessment of the reasonableness of parental views.¹¹² The Court of Appeal judgments do not support such an interpretation. They do dispel any suggestion that reasonableness of parental views is decisive,¹¹³ but this is not the main thrust of the judgments. The demand for a broad interpretation of best interests is unambiguous¹¹⁴ and unanimous. The discussion of the role of parental wishes is merely the technical means by which a ground for successful appeal is made out.

More pertinently, Waite LJ sets out a view of the role of parental wishes which fits comfortably with the carer's claim to narrow the court role to one of protection only (as the above interpretation of the House of Lords' decision in *Bland* suggests):

“...there is a scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for difference between parent and judge. In both situations it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child

¹¹² See, for example, Thorpe LJ in *Re C (A Child)(Immunisation: Parental Rights)* [2003] EWCA Civ 1148 at paragraph 21: “The outcome of that appeal is unique in our jurisprudence and is explained by the trial judge's erroneous focus on the reasonableness of the mother's rejection of medical opinion thus excluding other relevant factors.” He went on to those other relevant factors as “including the risks and consequences of the surgery, the mother's crucial role in the aftermath of surgery and the practical consideration that the judge's order would have required both parents, alternatively the mother alone, to return to the jurisdiction from a distant commonwealth country probably for the long period that the surgery and its aftermath would require.”

¹¹³ But Roch J was too simplistic when he said at p 255 that “it is ...misleading to ask, once it is accepted that the parents are devoted and responsible, whether their decision is reasonable or unreasonable because parents who are responsible and devoted will almost certainly reach a decision which falls within the range of decisions which can be classed as reasonable. If a decision falls outside the range of permissible decisions, it is unlikely that the parents are responsible and devoted parents who have sought only to decide in the best interests of their child.” In the context of sterilisation, the mother in *Re B* was applauded as devoted and responsible, but she still made an impermissible decision.

¹¹⁴ In addition to the references to Butler-Sloss LJ above, see Waite LJ at p524: “Had the judge viewed the evidence more broadly from the standpoint of his own perception of the child's welfare when appraised in all its aspects, he would have been bound in my view to take significant account of other aspects in this case.” And per Roch LJ at p256.

concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course a certainty) that the greater the scope for genuine debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature.”¹¹⁵

This approach is then criticised for giving undue weight to the mother’s own medical qualifications,¹¹⁶ but that reading too is misplaced.¹¹⁷ Butler-Sloss LJ¹¹⁸ is not persuaded by the mother’s arguments because she is a medical professional herself and therefore in some way to be equated with the treating medics¹¹⁹, but rather by a realistic assessment of the clinical implications of treatment proposed, and a willingness to see T in the context of the relationships on which the success of treatment depended.¹²⁰ The judgment simultaneously recognises both that there is a limit to what can be expected of third parties (even devoted mothers!), and that the support of third parties can be critical to successful outcome. The case was not – but could have been – decided the same way by reference either to utilitarianism or to an ethic of care. By contrast, Connell J’s approach at first instance is focussed excessively on the individual in

¹¹⁵ At p 254

¹¹⁶ Fox & McHale point out that the BMA regards treating members of one’s own family as unethical. Implicitly, the Court of Appeal drew a distinction between ‘treating’ and ‘caring’, but Fox and McHale suggest this was only possible because the Court ‘downplayed the importance of medical opinion’: ‘In Whose Best Interests?’ [1997] 60 MLR 700-709 at p704

¹¹⁷ An interesting comparison may be drawn with the case of *Re MM (Medical Treatment)* [2000] 1 FLR 224, where the mother was described by one doctor as “a very educated person in questions of immunology”. The case was in fact settled by agreement but the court recorded that it would have overridden parental objections to treatment, even though they were informed and ‘rational’, because the evidence that the proposed treatment was in the child’s best interests was ‘overwhelming’.

¹¹⁸ It is worth noting that she decided this case not long after completing the report of the Cleveland Commission, with all that that implies for her awareness of the dangers inherent in riding roughshod over families.

¹¹⁹ “As she said at p251, “If the decision in this case was a matter of assessing the clinical opinion of the doctors, the judge was clearly right to prefer their views to the mother’s, who could not be as well qualified to give an opinion. But this matter has to be looked at more broadly.”

¹²⁰ It is interesting to note that Butler-Sloss J was considering the case not long after she completed the Cleveland Enquiry. She would have been fully aware of the dangers lurking in too ready a dismissal of families.

the narrowest sense. It demands absolute self-effacement of carers in the preservation of life, even where the quality of life after treatment is questionable – an approach which is not suggested in any of the preceding authorities, least of all in the House of Lords in *Bland*.

Finally, it is suggested that *Re T* can be explained as falling into a special category of cases – organ transplants.¹²¹ It is certainly possible to see transplantation as a clinically more extreme version of the artificial prolonging of life achieved for Anthony Bland by artificial nutrition; and organ donations¹²² were mentioned in the category of ‘special treatment’ in *Re F*. However, there are too few cases of transplantation to examine for ‘special category’ status,¹²³ and in any event there is no need. The objections to *Re T* are really protests against a decision which looked beyond the clinical interests of the individual patient, and was prepared to countenance an outcome contrary to the first preference for preservation of life.

The case *should* be seen instead not as an aberration, but as evidence that the best interest test is capable, when interpreted broadly, of distinguishing the extreme from the run-of-the-mill, of facilitating extraordinary outcomes in extraordinary circumstances rather than forcing complexity into the straitjacket of universal norms – another ground for preferring the reasoning of the Court of Appeal in *Bland* to that of the House of Lords.

Preference Dilemma: There was nothing at all run-of-the-mill about *Re A (Children)(Conjoined Twins: Surgical Separation)*,¹²⁴ a case where it was not possible to fall back on the first preference for life:

¹²¹ The origin of this is probably the comment of Roch LJ at p256 that “The presumption on favour of the sustaining of life is not irrebuttable and perhaps has less weight where the issue is whether to prolong or not to prolong life by means of organ transplantation.”

¹²² Per Lord Donaldson at p19.

¹²³ The other reported case is *Re M (Child: Refusal of Medical Treatment)* [1999] 2 FCR 577 where the parents consent to a heart transplant for their 15 year old daughter, but the child herself refused. The court was concerned with issues of capacity, and in fact declared that the transplant would be lawful without the child’s consent. On the other hand, in November 2008 the Local Authority withdrew their application for a declaration in favour of a heart transplant operation for a 13 year old girl, Hannah Jones, who did not wish to undergo it. (See Elizabeth Grice, Guardian November 12th 2008, pB9)

¹²⁴ [2001] Fam 147

Twin girls, Jodie and Mary, were born joined at the pelvis and sharing a common artery. Mary's lungs and heart were too deficient to oxygenate and pump blood. Had she been a singleton, she would have died shortly after birth, but the common artery enabled Jodie's heart to circulate blood for both of them.

The treatment in issue was surgical separation of the girls. Separation did not involve any organ transplant or donation of bodily parts from one child to the other. If they were separated, Mary would die within minutes, but Jodie had the opportunity of "good quality life";¹²⁵ if they were not separated, both would die within 3 – 6 months "because Jodie's heart will eventually fail."¹²⁶

The parents refused to consent to the surgery. Their primary reasoning was a sincere belief that "it is God's will that the children are afflicted as they are and they must be left in the hands of God"¹²⁷ – moral reasoning based on mainstream religious faith, and backed by the Archbishop of Westminster.¹²⁸ In addition, they expressed fears that, living as they did on the tiny island of Gozo, with limited medical facilities, they would not be able to cope with a child with the serious disabilities they believed Jodie would have if she survived the operation.¹²⁹

If the treating doctors had taken the same view, or even if they had disagreed with it but been prepared to accept parental authority, "there could not have been the slightest criticism of them for letting nature take its course in accordance with the parents' wishes."¹³⁰ It was recognised that other medical teams may well have done just that. However, the twins happened to be born at St. Mary's

¹²⁵ At p163

¹²⁶ At p165

¹²⁷ At p155. The faith in question was Catholicism – professed by 1.131 billion people worldwide (according to the *Annuario Pontificio* 2008), so not an extreme cult by any reckoning. "Their view might be described as controversial but, unlike the objections to blood transfusions of Jehovah's Witnesses, they are not obviously contrary to any view generally accepted by our society. Still less are their views contrary to those generally accepted in the remote community from which they have come to this country." Per Robert Walker LJ at p 245

¹²⁸ Per Robert Walker LJ at p244

¹²⁹ At p172.

¹³⁰ At p173, per Ward LJ.

Hospital, where the medics neither agreed nor accepted parental authority, and so the question of surgical separation was referred to court.

The case posed two enormous legal problems, the first of which is our main concern. Since the two babies would experience opposite results from the same surgical intervention – one life, the other death – in determining whether surgery should go ahead or not, the court had in effect to choose between competing and incompatible interests. (The second problem, namely that since actions leading to death are usually prohibited and punished by the law of murder, is of lesser relevance to our consideration.¹³¹)

Any suggestion of preferring one life to another would have driven a coach and horses through many precious tenets of English law and morality, but in particular the principle of sanctity of life, that first preference which has shaped the courts' approach to best interests. Ward LJ (who lead the Court of Appeal's consideration of the first problem) was therefore scrupulous in placing the right to life of both of the babies into the balance.¹³² In order to distinguish between their best interests he adopted an argument from academia¹³³ and determined that the court's task was to strike a balance between the children by considering the *worthwhileness of the treatment*.¹³⁴ Given the different conditions of the babies,

¹³¹ Sabine Michaloski, in 'Sanctity of Life: Are Some Lives More Sacred Than Others?' (2002) Legal Studies 377, considers that this issue should have been the sole determining basis of the case, and that the logic and integrity of the criminal law points to surgical separation amounting to murder. Her view is flawless in logic, but somewhat sterile, failing as it does to give any appreciation of the real life situation, the *people* behind the case reports. Law is only necessary because there are people, with all that that implies in terms of needs, emotions, strengths, weaknesses and aspirations. To leave humanity out of the picture renders legal discussion absolutely otiose. Jenny McEwan, in 'Murder By Design: The 'Feel-Good Factor' and the Criminal Law'[2001] Medical Law Review 246, takes the same intellectual argument without the sterility. She says that the judgment is highly questionable in terms of law, logic and morality; it has left the law in a mess and it was achieved by a fudge, but she stops short of saying the decision was actually wrong. It is a luxury of commentary that commentators can criticise decisions, whereas judges actually have to make them!

¹³² At p 196, para 10(i): "The universality of the right to life demands that the right to life be treated as equal. The intrinsic value of their human life is equal. So the right of each goes into the scales and the scales remain in balance."

¹³³ John Keown, in 113 LQR 481 at 485, whose argument is itself based in the House of Lords judgment in *Bland*.

¹³⁴ "...the question is always whether the *treatment* would be worthwhile, not whether the patient's *life* would be worthwhile. Were one to engage in judgments of the latter sort, and to conclude that certain lives were not worth living, one would forfeit any principled basis for objecting to intentional killing" at p 187. Michael Freeman, in 'Whose Life Is It Anyway?'[2001]

the balance came down heavily in favour of Jodie.¹³⁵ Finally he put into the scales the manner in which the babies were individually able to exercise their right to life, on which he assessed Mary as “parasitic.”¹³⁶

The situation was appalling for the parents by accident of nature, but the court’s decision effectively forced them, against their instincts, to stand by and watch one of their children die for the sake of the other. Deciding the case against their wishes did cause Ward LJ discomfort.¹³⁷ The reasons he gave¹³⁸ were that they had assumed the worst possible outcome of surgery for Jodie; that although a disabled child represents a burden to parents, it is the best interests of the child, not the parents, which are paramount; and that in their repugnance at the idea of killing Mary, they failed to face up to the consequences for Jodie of not allowing surgery. Yet despite the enumeration of reasons for disagreement, Ward LJ’s position was really summarised in a single sentence: “In my judgment, parents who are placed on the horns of such a terrible dilemma simply have to choose the lesser of their inevitable loss.”¹³⁹

Such reasoning is clearly utilitarian. “Worthwhileness of treatment” is simply a linguistically tortuous way of saying that Ward LJ balanced the competing

Medical Law Review 259, considers that Ward LJ “got the right answer” but by the wrong reasoning. He considers that distinction between worthwhileness of treatment and worthwhileness of life is a nonsense, because the treatment is only worthwhile if the life is worthwhile. Freeman was willing to state that Mary’s life was worth less than Jodie’s, but this is a morally explosive statement, and impossible for any judge to make. In our system of precedent-made law, it would have implications way beyond what was under consideration in the particular case. That is not to say, however, that the actual reasoning was not in fact very similar. At p197, Ward LJ said that “The best interests of the twins is to give the chance of life to the child whose actual bodily condition is capable of accepting the chance to her advantage even if that has to be at the cost of the sacrifice of the life which is so unnaturally supported.”

¹³⁵ For the same reason, Brooke LJ (who lead the consideration of the second issue) determined that Fate, in the form of Mary’s weaker condition, had chosen which twin would be the victim of necessity. For either to live, it was necessary that one should die; Mary’s condition meant that she was self-designated. There was no human being deciding the balance, so no moral objection to the defence of necessity, and the operation would be lawful.

¹³⁶ P197, para (iv)

¹³⁷ “It gives me no satisfaction to have disagreed with their views of what is right for their family and to have expressed myself in terms they will feel are harshly and unfairly critical of them. I am sorry about that. It may be no great comfort to them to know that in fact my heart bleeds for them.” At p 196. In fact, tragically Ward LJ’s own daughter had died not long before he decided the case.

¹³⁸ At p 195-196

¹³⁹ At p 196 para (iv).

interests to see which decision produced the greatest good (or in the circumstances, the least bad).

This decision therefore took consideration of best interests to a new level.¹⁴⁰ The parents' interests in assuming or avoiding a burden of care were summarily dismissed, but giving weight to the interests of someone other than the patient herself could not be avoided, simply because the relevant treatment directly affected two patients at once. Mary's interests alone would undoubtedly have been *against* surgical separation. Those interests were simply outweighed by Jodie's opposite – and greater, in a utilitarian sense – interests.

The stark moral demands of the particular facts should not prevent us from recognising that the issue was essentially about how the best interests test can accommodate *competing* interests. Interests can – and do - compete in far less dramatic ways than life and death, and more or less directly. There is no reason in logic or morality why the same balancing exercise should not be carried out in less morally stark circumstances. Indeed, the same exercise could have been done to test the parents' case in respect of Jodie. Their interest in avoiding a burden of care with which they believed they could not cope would simply be outweighed by the greater imperative of sanctity of life, and the same decision would have been reached.¹⁴¹ The balancing exercise would still work however –

¹⁴⁰ And for this reason, it has been argued that the case was simply outside the proper remit of law. Barbara Hewson was instructed as Counsel for the Pro-Life Alliance, which was not a party to the case but was invited to make written submissions. She then published an article ('Killing Off Mary: Was the Court of Appeal Right?' [2001] Medical Law Review 281) to the effect that the court should have declined to hear the case, because really it amounted to a moral difference of opinion between the parents and the doctors, and it is arrogance to suggest that the court has any superior authority in areas of morality. Ward LJ anticipated this in his judgment at p155, where he said that "This court is a court of law, not of morals, and our task has been to find, and our duty is then to apply, the relevant principles of law to the situation before us"; and again at p 173, where he said "the only arbiter of that sincerely held difference of opinion is the court. Deciding disputed matters of life and death is surely and pre-eminently a matter for a court of law to judge. That is what courts are here for."

¹⁴¹ That the court *would* consider life to outweigh all other factors can be seen from the next case of life-saving treatment to be decided, *W Healthcare NHS Trust v. H* [2004] EWCA Civ 1324. The feeding tube of a 59 year old woman with multiple sclerosis (and incompetent for the preceding 20 years) had become dislodged. The "wonderful, caring" family (per Brooke LJ at para 11) did not want it reinserted, but the treating doctors did. The family's case was "as strong as it could be about the patient's horrible existence and wishes" (per Coleridge J, quoted by Brooke LJ at para 10). Yet, since the patient was sufficiently sentient to experience the effects of death by starvation, the judge was unable to say that the life-prolonging treatment would provide no benefit, and the Court of Appeal upheld his decision that her best interests required

and allow the possibility of interests other than the patient's prevailing – where the risk/benefit to the patient was less fundamental, and the burden to the family disproportionate.

Retreat to First Preference: Despite the opportunity that this presented for a more equitable approach to medical treatment in a family context, such an expanded use of the balancing exercise to determine best interests was not taken up in subsequent cases. As the emotional trauma of *Re A* subsided, so too did the concept of competing interests. Instead of shedding light on the limitations of an approach excessively focused on the individual, the unspoken imperative seems to have been to limit the decision to its specific – and traumatic – facts.

Instead, the lingering effect of *Re A* was fear. If the extension of best interest considerations could sanction death in that case, how far could it go? It was precisely that fear which motivated one Mr. James Burke to bring his application to court:

R (on the application of Burke) v. GMC:¹⁴² Mr. Burke suffered a degenerative physical disease. He sought judicial review of a GMC guidance document in respect of withholding and withdrawing life prolonging treatments. He was likely to remain competent until the very last stages of his life, and feared being left to die of thirst or starvation on the basis of someone else's assessment of his interests. He wanted a declaration that it would be unlawful to withhold/draw artificial nutrition or hydration.

reinsertion. Even when it is horrible, continued existence weighed most heavily in the balance. (Later cases, for example *Re K (A Child)(Medical Treatment: Declaration)* [2006] EWHC 1007, have accepted evidence that the distressing effects of death by starvation can be controlled by analgesic and anxiolytic medication (para 23), but there is no mention of the medics here offering that opinion. Why not? Possibly because the patient was an adult, so the question of advance directives altered the consideration. Or possibly because it did not suit the medical case?)

¹⁴² [2005] QB 424

Munby J¹⁴³ saw the case as focus[ing] on the extent to which we should respect autonomy.”¹⁴⁴ He referred to a “cluster of ethical principles which we apply to decisions about how we should live,”¹⁴⁵ adding to sanctity of life and respect for autonomy, a respect for the dignity of the individual human being, which he then sought to elevate by means of an expansive interpretation of best interests:

“..evaluation of a patient’s best interests involves a welfare appraisal in the widest sense, taking into account, where appropriate, a wide range of ethical, social, moral, emotional and welfare considerations....Indeed it would be undesirable and probably impossible to set bounds to what is relevant to a welfare determination.”¹⁴⁶

He emphasised that the determination of best interests is not for the doctors, but for the patient if competent and the court if not.¹⁴⁷ The assessment has to be made from the perspective of the particular patient, and - most importantly – he accepted that its “touchstone” was intolerability.¹⁴⁸

What does that mean? “Touchstone” is defined in the Oxford English dictionary as

- (1) a finegrained dark schist or jasper used for testing alloys of gold etc. by observing the colour of the mark which they make on it.
- (2) a standard or criterion

¹⁴³ Who had appeared as Counsel in many of the leading cases in this area of law, including *Re F* [1990] 2 AC, *Re J* [1991] Fam 33, *Re T* [1992] 3 WLR 782, *Re T (Adult Refusal of Treatment)* [1993] Fam 95, *Re S* [1993] 1 FLR 26 and *Airedale NHS Trust v. Bland* [1993] AC 789.

¹⁴⁴ P429

¹⁴⁵ P443, quoting from *Airedale NHS Trust v. Bland* [1993] AC 789

¹⁴⁶ Pp455 and 457

¹⁴⁷ At p465: “Doctors can properly claim expertise on medical matters; but they can claim no special expertise on the many non-medical matters which go to form the basis of any decision as to what is in a patient’s best interests. Medical opinion, however eminent, can never be determinative of what is in a patient’s best interests.” He even went so far as to say that, even if a court could not grant a mandatory order requiring an individual doctor to treat a patient, after *Re J*, he saw “no reason in principle why the court should not...grant declaratory relief against him” at p 487

¹⁴⁸ At p 463 para111 and again at p465 para116(12).

It is usually understood to indicate a test for something.¹⁴⁹ Therefore, Munby J was suggesting that if the continued existence which treatment would offer was intolerable to the patient, his best interests permitted withdrawal/withholding of it.

The judgment is impressively erudite, but it ranges way beyond the scope of Mr. Burke's concerns. In essence Munby J equates best interests with the wishes of a competent patient,¹⁵⁰ allowing him to say that "Important as the sanctity of life is, it may have to take second place to human dignity." As a response to the fear engendered by the court sanction of death in *Re A*, these were powerful words. Patients heard the message, loud and clear, that *they alone* held the power to decide their treatment – even where doctors disagreed, and even if that meant choosing death over life. The power of doctors was curtailed, and families were ignored,¹⁵¹ but both disability rights groups and the pro-euthanasia lobby were delighted.

The Court of Appeal, on the other hand, was dismayed. It could see where such a view of the law might lead, and was anxious to stop it.¹⁵² A single judgment¹⁵³ was handed down, in which the judges first analysed Mr. Burke's fear, and then dismissed it as groundless,¹⁵⁴ criticising the hijacking of his case by others with

¹⁴⁹ Although it is doubtful that Munby J ever intended it to be seen quite so starkly, as the Court of Appeal recognised. Others however did seize on the touchstone approach as a workable tool (see for example the arguments of the parents in *Portsmouth NHS Trust v. Wyatt* [2005] EWHC 693).

¹⁵⁰ As the Court of Appeal noted at para 27.

¹⁵¹ At least in so far as they might claim interests of their own. There would be space to recognise the patient's interest in the family within the wide concept of best interests, and the family would have the right to refer a case to court if they felt that withholding/drawing ANH was contrary to the patient's wishes or interests (para 202), but the former is not a family interest, and the latter is more akin to a "substituted judgment" role than recognition of their own interests.

¹⁵² And their fears were quickly justified - the public appetite for such an approach was considerable. Within 6 weeks, the Court of Appeal had cited parts of Munby's judgment with approval in *W Healthcare NHS Trust v. H* [2005] 1 WLR 834, and within 7 weeks, another high profile case had been decided which relied on an interest in dignity of death – *Portsmouth NHS Trust v. Wyatt* [2004] EWHC 2247, discussed below.

¹⁵³ Thereby increasing the force of the decision by emphasising its unity.

¹⁵⁴ From para 8 of his statement (para 6 of the judgment), "I am concerned that even if my death is not imminent, a doctor may be able to withdraw artificial nutrition and hydration". The dismissal came in para 13: "There are no grounds for thinking that those caring for a patient would be entitled to or would take a decision to withdraw ANH in such circumstances"; and again at para 40, "...the doctor with care of Mr. Burke would himself be obliged, so long as the

their own agenda.¹⁵⁵ They curtly reprimanded Munby J for “setting out a textbook or a manual” and allowing the court to be “used as a general advice centre.”¹⁵⁶ Paradoxically, they were so desperate to quash Munby J’s judgment, that they felt obliged to answer it point by point.¹⁵⁷ They drove back the concept of best interests into context-dependency; and then in the context of treating an incompetent patient, they confined its meaning to an objective test.

Two aspects of the Court of Appeal’s approach to best interests merit further attention. Firstly, the Court of Appeal rejected the ‘touchstone’ approach¹⁵⁸ - the idea of a single benchmark, whatever the circumstances. This rather begged the second point, namely the scope of best interests considerations. Rather than addressing directly the issue of what factors may be relevant, the Court of Appeal simply stated that the concept is “easiest to apply when confined to a situation where the relevant interests are medical.”¹⁵⁹ Does that mean that the intention was to limit the interests of incompetent patients to medical considerations only?

It seems unlikely. Given the urgency to discredit expressly most of the conclusions of Munby J, the absence of contradiction of his inclusive view of best interests indicates tacit acceptance.¹⁶⁰ It is indeed *easier* to assess best

treatment was prolonging Mr. Burke’s life, to provide ANH in accordance with his expressed wish. We do not believe that this has ever been open to doubt.”

¹⁵⁵ Para 14. Mr. Burke’s litigation was supported by the Pro-Life lobby. See Charles Foster, “Burke: a Tale of Unhappy Endings” [2005] JPI Law 293.

¹⁵⁶ Paras 19 and 21. “The danger is that the court will enunciate propositions of principle without full appreciation of the implications that these will have in practice, throwing into confusion those who feel obliged to attempt to apply those principles in practice. The danger is particularly acute where the issues raised ethical questions that any court should be reluctant to address, unless driven to do so by the need to resolve a practical problem that requires the court’s intervention.”

¹⁵⁷ It would be “inappropriate to leave the judgment to be seized on and dissected by lawyers seeking supportive material for future cases...we counsel strongly against selective use of Munby J’s judgment in future cases.” Para 24

¹⁵⁸ Paras 62 & 63.

¹⁵⁹ Para 29. Such scant consideration of best interests has been criticised elsewhere. Charles Foster, in “Burke: a tale of unhappy endings” [2005] JPIL 293 at 301, accused the Court of Appeal of being “naïve and dangerous” in implying that judges need no help in deciding what “best interests” means – “A ‘best interests’ test simpliciter is so elastic as to be meaningless”.

¹⁶⁰ At paragraph 24 the Court of Appeal acknowledged that “a great deal of what is contained in the body of the judgment is uncontroversial”. Numerous cases had already broadened the scope of best interest beyond medical interests to include ‘medical, emotional and all other welfare issues’, eg *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541 at 555, and *Re A (Male*

interests where the only considerations are medical, but that does not make it impermissible to include other considerations where appropriate. The context of the Court of Appeal judgment has to be considered just as much as the context of the best interests test, and the Court of Appeal was trying to squash a judgment which seemed to open the door to euthanasia for competent patients, not limit the interests of incompetent patients. Nonetheless there is retreat here from the previous willingness of differently formulated Courts of Appeal to adopt wider views. It is a reactionary judgment, entrenching the line that the earliest cases had established: strong respect for life, a principle of autonomy, and judicial assessment of best interests where patients are unable to decide for themselves.

Rebutting the Preference, With Tools Salvaged in Retreat: Whilst the judgment of Munby J held sway, before the Court of Appeal took back the tiller, the common law held its breath.¹⁶¹ Others eager to rely on his judgment were forced to wait – for five months, in the case of the next standard-bearing litigation, that of *Portsmouth NHS Trust v. Wyatt*.¹⁶²

Baby Charlotte was born at 26 weeks gestation, with chronic respiratory and kidney problems and deficient brain growth. The medical evidence was that she had no sense of sight or sound and was effectively without volition; she experienced pain, but it was

Sterilisation) [2001] 1 FLR 549 at 555. It is indeed *easier* to assess best interests where the only considerations are medical, but that does not make it impermissible to include other considerations where appropriate. The context of the Court of Appeal judgment has to be considered just as much as the context of the best interests test, and the Court of Appeal was trying to squash a judgment which seemed to open the door to euthanasia for competent patients, not limit the interests of incompetent patients. It is a reactionary judgment, entrenching the line that previous cases had established: strong respect for life, a principle of autonomy, and judicial assessment of best interests where patients are unable to decide for themselves.

¹⁶¹ Although parts of Munby J's judgment were cited with approval by the Court of Appeal in *W Healthcare Trust v. H & Others* [2005] 1 WLR 834 at para 24.

¹⁶² [2005] EWCA Civ 1181. Per Wall LJ at para 40-42: “..the hearing of Mr. & Mrs. Wyatt's appeal had unfortunately been substantially delayed. The reason for this was that at the date of the appellants' notice (28th April 2005) there was pending in this court an appeal by the GMC against a decision of Munby J in *Burke*...In the course of his wide-ranging judgment Munby J had accepted a submission...in relation to the formulation of the “best interests” test on which Mr. and Mrs. Wyatt wished to rely, but which it was thought this court was likely to review...In the event this court's judgment in *Burke* was not handed down until 28th July 2005 with the consequence that Mr. and Mrs. Wyatt's appeal had to be heard in the long vacation. The result of this is that, when Mr. and Mrs. Wyatt's appeal was heard in this court on 25th August, more than 5 months had elapsed since Hedley J heard the evidence in the case, and more than 4 months since he had given judgment.”

doubtful whether she could feel pleasure. The medical team sought declarations authorising them not to use artificial ventilation if her condition deteriorated. Against the parents' wishes, declarations were granted in October. Contrary to medical expectation, Charlotte survived the winter. Although there was no improvement in her condition, so that she remained terminally ill, its consequences were substantially ameliorated, and in particular her oxygen dependency was significantly improved. The parents applied to discharge the declarations.

When Hedley J had granted the original declarations he identified the understanding and concept of 'best interest' as the true difficulty in the case.¹⁶³ He adopted a "generous interpretation,"¹⁶⁴ but he allowed intolerability only as a "valuable guide" to, not a gloss on or supplementary test to best interests;¹⁶⁵ and then he did the balance sheet exercise. In an echo of Munby J's paeon to human dignity,¹⁶⁶ he had included Charlotte's interest in "securing a 'good' death";¹⁶⁷ in an echo of Ward J's assessment of Mary in the conjoined twins case, he included her prospects of physical survival, on which the prognosis was minimal. Together these factors outweighed sanctity of life.

Again, the judge had expressed discomfort at reaching conclusions contrary to parental wishes.¹⁶⁸ He asked himself what weight was to be attached to their views. This verbal formulation might suggest acknowledgment that parental views are actually an interest of the patient's to be put into the balancing exercise, but the answer he gave himself belies such an interpretation, for he

¹⁶³ [2004] EWHC 2247 at para 22.

¹⁶⁴ [2004] EWHC 2247 at para 23. He went on to quote from *Re A (Male Sterilisation) and Re S (Adult Patient: Sterilisation)*.

¹⁶⁵ [2004] EWHC 2247 at para 24. He explained at para 38 that "Although I believe and find that further invasive treatment would be intolerable to Charlotte, I prefer to determine her best interests on the basis of finding what is the best that can be done for her."

¹⁶⁶ Munby J had given judgment in *Burke* on 30th July 2004; Hedley J gave judgment in *Wyatt* on 7th October 2004. At para 27, Hedley J set out the "fundamental principles of sanctity of life, the best interests of Charlotte...and *her inherent right to respect for her dignity*." (italics added)

¹⁶⁷ At para 28. "It would be absurd to try to describe that concept more fully beyond saying that everyone in this case knows what it means – not under anaesthetic, not in the course of painful and futile treatment, but peacefully in the arms of those who love her most."

¹⁶⁸ See para 34 and 39: "it is my one regret that my search has lead to a different answer than that sought by these parents."

simply restated the conventional approach.¹⁶⁹ A respectful, and critical, attitude to parental views was all that he considered to be required – even when the parents were conducting themselves entirely appropriately.¹⁷⁰

By the time the application to discharge the declarations was heard, the stress of the situation was telling on everybody, and the conduct of the parents was much more challenging. The family had reported the doctors to the police, claiming serious offences in relation to her care. Mr. Wyatt had to be accompanied on all hospital visits by a member of security staff, following an assault on medics. Further proceedings had been necessary to extend the ambit of clinical discretion after Mr. Wyatt sought to intervene in routine decisions about drug levels to be administered.¹⁷¹

Hedley J stuck to his view of best interests,¹⁷² and was more robust in his support for the majority medical opinion.¹⁷³ This time there was no expression of discomfort at disagreeing with the parental view when he refused their application.

It was the approach to intolerability which necessitated delay in the case. The parents wished to rely on the touchstone approach, arguing that Charlotte's life was not intolerable to her.¹⁷⁴ Once the Court of Appeal in *Burke* had rejected that approach, the Court of Appeal in *Wyatt* was able to support Hedley J. Although 'intolerability' was ruled out as a 'touchstone', the concept was not banished altogether – presumably because as a tool for judgment, it is too useful. Wall LJ's formulation of its role is a masterful exercise in obfuscation:

¹⁶⁹ Namely that he should "remind [him]self in [his] consideration of Charlotte's best interests that Mr. and Mrs. Wyatt know her best. [He] should pay proper attention to their intuitive feelings whilst reminding myself that they may project those on to Charlotte." (para 34)

¹⁷⁰ At para 42, Hedley J acknowledged "the dignity" of the parents and their "commitment" to Charlotte, showing "a generous spirit in adversity".

¹⁷¹ See Hedley J [2005] EWHC 693 at para 18, and Wall LJ [2005] EWCA 1181 at para 21.

¹⁷² More confidently, since it had by then been affirmed by Dame Elizabeth Butler-Sloss in *Re L (A Child)* [2004] EWHC 2713, as Hedley J pointed out at para 14.

¹⁷³ "I am quite clear that it would not be in Charlotte's best interests to die in the course of futile aggressive treatment" para 16.

¹⁷⁴ See para.s 59-62 of the CA decision. It is worth noting that Mr. and Mrs. Wyatt were represented by David Wolfe QC, who had acted for the Disability Rights Counsel in *Burke* and whose submission in that case posited to Munby J the notion of intolerability as a touchstone for best interests.

“ whilst ‘intolerable to the child’ should not be seen as either a gloss on or a supplementary guide to best interests, it is....a valuable guide in the search for best interests in this kind of case.”¹⁷⁵

What is the difference between a “supplementary” guide and a “valuable” guide? The answer lies in Wall LJ’s reasons for rejecting the touchstone approach:

“..the forensic debate should... be unfettered by any potentially contentious gloss on the best interests test which are likely either inappropriately to shift the focus of debate, or to restrict the broad exercise of the judicial discretion involved in balancing the multifarious factors in the case.”¹⁷⁶

In other words, judges can use intolerability to help them make their own decision; but no one else must use intolerability to tell judges what decision to make. It is a difference of locus of power. The Court of Appeal’s decision displays determination to keep decisions about life and death treatment exclusively in the hands of the judiciary. There is a public interest in life-and-death medical decisions for patients lacking capacity, and the best interests test is manipulated by the court to ensure its protection.

Instead of permitting any “gloss” on the discretionary interpretation of the best interests test, Wall LJ restated the established principles in a list of “intellectual milestones”¹⁷⁷ for judges. This approach – which is nothing more than a revision guide - proved more useful to judges, as was demonstrated when the court was next asked to implement the best interests test:

¹⁷⁵ Para 91

¹⁷⁶ Para 86

¹⁷⁷ Para 87: “The judge must decide what is in the child’s best interests. In making that decision the welfare of the child is paramount, and the judge must look at the question from the assumed point of view of the patient...There is a strong presumption in favour of a course of action which will prolong life, but that presumption is not irrebuttable...The term ‘best interests’ encompasses medical, emotional, and all other welfare issues...The court must conduct a balancing exercise in which all the relevant factors are weighed....and a helpful way of undertaking this exercise is to draw up a balance sheet.”

An NHS Trust v. MB:¹⁷⁸ M was an 18 month old child with severe spinal muscular atrophy. He had virtually no movement other than of his eyes, and he had been unable to breath without artificial ventilation for more than 7 months. Early death was inevitable, but he was conscious, and assumed to be able to see, hear and feel touch, with an awareness of his surroundings and people. The Trust sought leave to withdraw ventilation, but the parents wanted a tracheostomy for long-term ventilation.

There were significant differences to *Wyatt* on both sides of the argument. The treatment in question was the same, but here the medical team were trying to stop something they had already started, rather than secure approval for never starting it in the first place. And the parents were unimpeachable.¹⁷⁹ The medical team apparently saw no difference between M's condition and Charlotte's,¹⁸⁰ but the judge did.¹⁸¹ Though small, the benefits M experienced in life were sufficient to tip the balancing scales in favour of continued treatment. Escalated treatment, however, would not be justified.

¹⁷⁸ [2006] EWHC 507 in which Holman J at para 17, "doubt[ed] [his] own intellectual capacity on the one hand to exclude [intolerability] even as a 'gloss on', much less supplementary test to, best interests; and yet on the other hand treat it as a 'valuable guide'. If it means no more than that the conclusion that is in the best interests of the patient to be allowed to die should only be reached in a clear and strong case, then that is already part of the intellectual milestones.." For him intolerability "really expresses a conclusion rather than provides a test."

¹⁷⁹ Holman J described the mother's commitment at some length at para 42: "Almost every day she is at the hospital and with him from about 12 noon until about 8.45pm – ie over 8 hours and longer at weekends...I have to caution myself that she cannot, because of her relationship, be objective; but it is the fact that no one other person has spent so much time with M and been as intimate in their contact with him. I do consider that she is, in various respects, very understandably and humanly, deluding herself. But I consider her to be entirely honest in evidence; and even if not wholly objectively reliable, considerable weight has to be attached to her account as a source of evidence."

¹⁸⁰ Eight doctors of consultant status made statements supporting the Trust, but none of them made any reference to, or gave any recognition of, any possible current pleasure or benefit to M from his life: para 26.

¹⁸¹ Para.s 63- 69. Then at para 102 "It is impossible to put a mathematical or any other value on the benefits. But they are precious and real and they are the benefits, and only benefits, that M was destined to gain from his life. I do not consider that from one day to the next all the routine discomforts, distress and pain that the doctors describe...outweigh those benefits so that I can say that it is in his best interests that those benefits, and life itself, should immediately end. On the contrary, I positively consider that as his life does still have benefits, and is his life, it should be enabled to continue..."

How much was the decision based on the fact that artificial ventilation had already been started? Such reasoning was not expressed. M's condition had deteriorated since its commencement. Reasoning along these lines would have suggested that doctors could never review the appropriateness of treatment – clearly an absurd proposition.

How much instead was the decision to do with regard for the parents? Comparison with the subsequent cases of *Re K (A Child)(Medical Treatment: Declaration)*¹⁸² and *Re B (Medical Treatment)*¹⁸³ suggests that the parental role was significantly contributory. Certainly it would have been very harsh to a selflessly devoted mother to grant the application. M was not in a persistent vegetative state. Whatever the legal niceties, it would have felt like there was no distinction between stopping treatment and causing death. How much was it due to the fundamental respect for sanctity of life? It took only very small benefits to attract the protection of the court.

Conclusions: The approach of the courts to disputes about life-preserving treatment has now crystallised.¹⁸⁴ The best interest test has been shaped by a moral debate about dominion over life and death. Preservation of life is a clear first judicial preference, but life is not sacred beyond all other considerations, and the preference can be rebutted. The ultimate decision may be more moral than legal, but courts demonstrate persistent determination to hold determining authority, in preference to either medics or families.

¹⁸² [2006] EWHC 1007. Sir Mark Potter P himself makes the comparison at para.s 53 – 57 inc. Listing the differences between the cases, he includes as a positive factor for M that “he is in a close relationship with a family that have spent and are able to spend very considerable time with him”. In contrast, K's parents had been unable to care for her and she had been taken into care from birth. Her mother was kept informed of K's condition and accepted the move to palliative care; her father said that he visited daily, but did not oppose the application. The only reference to their active involvement in caring was the proposal that K could spend her last days in a hospice, where the parents could also stay, being provided with full care and hotel services.

¹⁸³ [2008] EWHC 1996, where the profoundly disabled child's mother was herself a minor, and the child was being looked after by foster carers.

¹⁸⁴ See for example the recent cases of *Re B (A Child) (Medical treatment)* [2008] EWHC 1996 and *Re OT* [2009] EWHC 633. The case note of the latter recites the highlights of the cases listed above, almost with an air of ennui, and the case itself firmly asserts compliance of the court approach with the European Convention.

When life in all but the narrowest sense is lost already, the House of Lords determined that the best interests test could not be relevant, but on the way the Court of Appeal showed how it could encompass much wider concerns than purely the patient-focused. Unfortunately the two cases which most reflect this wide interpretation, *Re T* and *Re A (Conjoined Twins)*, were characterised by loss of life, or the expectation of it. Taken up by pro-euthanasia campaigners in *Burke*, the court was driven into retreat, out of public interest considerations. Subsequent cases reserved the notion of ‘intolerability’ as a prop for judicial thinking, but left ‘best interest’ considerations in the thrall of the first preference for preservation of life, and once again bound to a patient-focused, medically-centred interpretation.

It need not be so. Even if the court is to retain ultimate authority, in the balancing exercise they have adopted a mechanism for decision-making which is consciously liberated from strict principle or ethic, and looks instead to protection and pragmatism. As select authorities demonstrate, there is space within the existing milestones (in logic and in practice), to accommodate family interests, both in their own right and in competition with the patient’s. It does not undermine the patient’s interests to put them in context, anymore than opinions are quashed by hearing two sides of the argument. On the contrary: it strengthens a valid case, and shows up the weakness of an invalid one. If fear of treatment decisions which do not preserve life is not enough to exclude judicial capacity for making them, then neither should it be sufficient to exclude from consideration factors which may incline judicial thinking that way.

C. Borderline capacity

One of the clearest, and most treasured, tenets of medical law is that the autonomous patient can *refuse* treatment, even if - on any objective assessment - it would be in his best interests to accept it. A competent patient can reject what

is good for him for any reason, or indeed for no reason at all.¹⁸⁵ It is a fine and liberal principle, deservedly at the heart of a society that wishes to be open to the freedoms of its citizens.

However in reality, when patients make decisions which apparently run counter to the best interests of their health, there is a clash of expectations. The instinct of the medical profession to heal is affronted. The response is often to question the *capacity* of the patient to make her own decision. If a patient lacks capacity to make a treatment decision, then the doctor is free to treat according to his own perception of the patient's best interests.

When the dispute is referred to the higher authority of the judiciary, the court's bluff is called: how far will the law really leave people to suffer the consequences of their own decisions? The court holds the power to determine capacity, and therefore performs a 'gate-keeping',¹⁸⁶ role to the exercise of autonomous choice. Before the patient can choose to refuse, she must first satisfy the judge that she is capable of making the choice. Judicial determination of competency, or rather the absence of it, shuts off individual choice and opens the door to judicial – and therefore objective – assessment of best interests.

Consideration of medical treatment cases where courts first determined the existence or otherwise of competence, reveals something about both the content of 'best interests' as a judicial concept, and the reality behind the principle of autonomous choice. Once again, the source of the (potential) incapacity makes a difference, and it is therefore necessary to consider adult and minor patients separately.

Adult Patients

Adults are assumed to be competent unless the contrary is shown. However, the existence of a right to choose whether or not to accept treatment does not

¹⁸⁵ "It matters not whether the reasons ... were rational or irrational, unknown or even non-existent" per Lord Donaldson in *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782 at p115.

¹⁸⁶ A phrase used by Huxtable in 'Whatever you want? Beyond the Patient in Medical Law' (2008) *Health Care Anal* 288 at p295.

necessarily imply that the right has been exercised; and even if some preference has been expressed, its extent and limits may be open to question. In situations of medical crisis, the very fact of decision-making is laden with opportunity for challenge.

When a choice is not a choice: In the case of *Re T (Adult: Refusal of Treatment)*¹⁸⁷ the patient's apparent choice to refuse treatment put her life in jeopardy. Although doctors were prepared to accept her refusal, some family members were not:

T was aged 20, and 34 weeks pregnant. After sustaining injuries in a road traffic accident she was taken into hospital, where she was diagnosed as suffering from pneumonia. Drugs were administered but her condition deteriorated. T spontaneously said that she did not want blood transfusion, although none was in contemplation at the time.

In premature labour, T was moved to a maternity hospital where it was decided to deliver the baby by Caesarean section. When T reiterated her refusal of blood transfusion, she was reassured that transfusion was not usually necessary; and when she asked about alternatives, she was given a falsely optimistic assessment. T then signed a refusal of consent form, without either reading it or being given an explanation.

The baby was still born, and T's condition deteriorated further, falling into unconsciousness. T's father and boyfriend applied to court for a declaration that it would not be unlawful to administer a blood transfusion.

¹⁸⁷ [1992] 3 WLR 782

In a late sitting at the judge's lodging, Ward J found that T was not fully rational when she signed the refusal form, due to her condition and the effects of narcotic medication. He granted the declaration, and the blood transfusion was given.

In an emergency situation, where the patient's life was in danger, and the treatment proposed uncontroversial to the majority of the population, judicial instinct was to question capacity and find it wanting, on the basis of the very condition which demanded its exercise; and then to protect the patient from herself. As the law was applied, T had lost her competency a good while before she lost consciousness.

Two days later, at the full hearing, the medical evidence changed. Ward J then felt compelled to conclude instead that T's ability to make a rational decision was intact when she signed the refusal form. Nonetheless, he stuck to his conclusion of incapacity, justifying it instead by the misinformation about alternative treatments: T had been lulled into a false sense of security, so that her refusal did not extend to the situation of emergency which subsequently transpired.

In other words, although T had freely refused treatment, she had not understood that to mean refusal of the only possible life-saving treatment, and therefore her refusal was not valid when that became the reality. She had not chosen *enough* for the court to allow autonomy to carry the day.

The Official Solicitor appealed. The Court of Appeal would have been prepared to find that T lacked capacity on the basis of her medical condition alone¹⁸⁸ - which suggests that it would be difficult for *anyone* in circumstances of medical crisis to satisfy the conditions of autonomy sufficiently to make a valid refusal of (relatively minor but) life-saving treatment – but the appeal was decided on different grounds. T's spontaneous rejection of blood transfusion, and its repetition at the maternity hospital, had been voiced when only her mother was

¹⁸⁸ Per Lord Donaldson at p 111: "I think that there is abundant evidence which would have justified this court in substituting findings that T was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities

with her, and her mother was a Jehovah's Witness.¹⁸⁹ The influence of the mother's faith had been a bone of contention throughout T's life¹⁹⁰ and was central to the Court of Appeal's view of her ability to make her own decisions. All three judges were agreed that the influence exerted by her mother would alone have been sufficient to vitiate T's supposed autonomy.¹⁹¹

The Court of Appeal decision draws a line between individual autonomy and family support. T's mother was counselling her daughter at a time of need in the way that she thought best. We cannot know what support T derived from her mother's presence at her bedside, beyond what can be inferred from T *not* asking her mother to leave. The offering of advice and assistance is welcomed by the court - up to a point¹⁹² - but when advice and assistance becomes direction,¹⁹³ the locus of decision-making authority is altered and autonomy is overborne.

The very circumstance of medical decision-making, and the fact of intimate relationship, collude in a tendency to reach the point of overbearing sooner than may otherwise be the case:

¹⁸⁹ Ward J had been aware of "the mother's fervent belief in the sin of blood transfusion" (quoted by Butler-Sloss LJ at p 118), but it had not formed the stated basis of his conclusions.

¹⁹⁰ T's parents had separated when she was a young child. T had originally stayed with her father, until her mother refused to return her, when there were contested residence proceedings. T's custody was given to the mother, but she was forbidden to bring T up as Jehovah's Witness. Although T grew up in a household where her mother pursued her beliefs, she was never baptised. Aged 17, T had gone to live with her grandmother and resumed a relationship with her father. The following year she had started living with her boyfriend, thereby choosing a lifestyle in contradiction to Jehovah's Witness beliefs.

¹⁹¹ As Lord Donaldson continued, "even if, ...she would otherwise have been in a position to reach such a decision, the influence of her mother was such as to vitiate the decision which she expressed."

¹⁹² The patient is "entitled to receive and indeed invite advice and assistance from others in reaching a decision, particularly from members of the family. But the doctors have to consider whether the decision is really that of the patient. It is wholly acceptable that the [patient should have been persuaded by others of the merits of such a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision. The real question in each case is "Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?" per Lord Donaldson at p113.

¹⁹³ And when the advice in question is *contrary* to medical opinion it is likely to be seen as crossing the line between support and direction rather sooner than if it supports medical orthodoxy. If T's mother had not been a Jehovah's Witness, and had been counselling her daughter to *accept* blood transfusion would her influence have been challenged?

“When considering the effects of outside influences, two aspects can be of crucial importance. First the strength of will of the patient. One who is very tired, in pain or depressed¹⁹⁴ will be much less able to resist having his will overborne than one who is rested, free from pain and cheerful. Second, the relationship of the ‘persuader’ to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships.”¹⁹⁵

So, almost by definition, the family’s role in medical treatment decisions is, according to this view, to be excluded.

Yet it was also family members who took T’s situation to court,¹⁹⁶ thereby enabling the court to become involved. The driving force behind the interpretation of T’s decision at both levels of court is not exclusion of families, but simple protectionism. Ward J, in a situation of immediate crisis, prioritised life over autonomy, denying the latter in order to secure the former. The Court of Appeal would have done the same, but in greater leisure could dress its conclusions in the language of individual autonomy.¹⁹⁷ Even then, the apparent support for autonomy is illusory. Autonomy is not preserved; it is simply replaced by the court, instead of by the family.

For T, the result was that she was denied effective support from anywhere. The medical information was dismissed by the court because it was misleading;¹⁹⁸

¹⁹⁴ Which must surely encompass just about everybody with a significant medical decision to make!

¹⁹⁵ Per Lord Donaldson at p114

¹⁹⁶ Lord Donaldson at p106 actually criticises the doctors for *not* referring the matter to court: “T’s father and [boyfriend] decided to seek the assistance of the court. Quite how they set about it I do not know, but it was an unusual and...praiseworthy initiative. It was also one which...should have been taken by the hospital authorities themselves on the Monday.”

¹⁹⁷ As a mechanism for restricting family influence it is clumsy and tactless. How much more effective in preventing undue influence would it be to give overt recognition to family views? Once out in the open, the threat of hidden influence recedes. The family view can be dismissed on its own merits, without insult to a patient’s competence.

¹⁹⁸ If ‘misleading’ advice vitiates autonomy, then doctors have a simple way of manoeuvring all patients that they want to treat into a situation of non-autonomy. The suggestion may be cynical,

and the mother's advice was dismissed because it was overbearing. T was therefore deemed incapable of making a decision at all, and the court stepped in to apply its own best interests test.

What lies behind the court's need to take control is the conflict between two interests – that of the patient, and that of the society in which he lives.¹⁹⁹ It may be clear in law that in the ultimate the right of the individual is paramount, but in practice the effect of conflict is simply to shift the position of the problem, and require a very careful examination of whether, and if so the way in which, the individual is exercising that right. In cases of doubt, as *Re T* demonstrates, the courts come down on the side of public interest²⁰⁰ and the preference for life over death, at quite a high cost to the integrity of the individual.

The understanding of capacity: In order to achieve the protectionist outcome, the understanding of what capacity is gets distorted. Throughout the judgments of *Re T*, 'autonomy' is discussed in very robust terms, as if it is a clear and absolute condition, when in reality (and particularly in illness), it is more likely to be experienced in shades of grey. Lord Donaldson was looking for a capacity "commensurate with the gravity of the decision"²⁰¹ to be made. The more serious the decision, he said, the greater the capacity required – and what could be more serious than a life-and-death decision?

This understanding of capacity persists through the cases that followed,²⁰² but it is ethically mistaken, because it conflates seriousness of effect with complexity of the decision-making process when in logic and in reality, there is no such

but there is an obvious parallel with the paternalistic practice of bowdlerising the information given to minor patients, with the end result that their understanding is so partial as to enable their views to be discounted: see for example *Re L (Medical Treatment: Gillick Competency)* [1998] 2 *FLR* 810.

¹⁹⁹ As Lord Donaldson explicitly acknowledged at p112: "The patient's interest consists of his right to self-determination – his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible."

²⁰⁰ Lord Donaldson is unapologetic about this at p112: "doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms".

²⁰¹ At p113

²⁰² See for example Thorpe J in *LB v. Croydon DHA* [1995] 1 *FCR* 332 at p773, and Butler-Sloss LJ in *Re MB* [1997] 2 *FLR* 426 at p 437

corollary between the two.²⁰³ In truth, the corollary is between seriousness of effect and court difficulty in acceptance.

Only when the issue came before the courts in a medical timeframe of comparative leisure, was the court able to express a more informed approach to the assessment of competence:

Re C (Adult: Refusal of Treatment).²⁰⁴ The 68 year old patient was a chronic schizophrenic serving a prison sentence in a secure hospital. His ulcerated foot became gangrenous. He refused to consent to amputation, but agreed to more conservative treatment, which averted the immediate crisis. When the hospital refused to give any undertaking not to amputate in the future, C sought an injunction to prevent amputation without written consent.

Thorpe J identified three stages of making the decision as to medical treatment:²⁰⁵ firstly, taking in and retaining treatment information; secondly, believing it; and thirdly weighing that information, balancing risks and needs. C's reason for refusing amputation, that he would "rather die with two feet than live with one,"²⁰⁶ would not be compelling for most of us, but the medical evidence failed to establish that his general capacity was so impaired by schizophrenia as to render him incapable of any stage of the decision-making process. Therefore his right to self-determination was not displaced, and the injunction was granted.

On the face of it, this decision seems boldly supportive of autonomy, even where its exercise would mean the loss of a preservable life, but how bold was it really? C's right to make an absurd choice was upheld at a time when the decision was merely a hypothetical one (and he had already proved the medical predictions of death without amputation false on one occasion). It is a moot point whether the

²⁰³ See earlier discussion in chapter 2.

²⁰⁴ [1994] 1 WLR 290

²⁰⁵ At p 292

²⁰⁶ At p291

same court would have had the courage of that conviction if the proceedings had been brought not as an injunction, but in the throes of medical emergency. It would not seem difficult to recast a preference for two dead feet over one living one, not as idiosyncrasy, but as failure to weigh information and balance risk.

Exactly such recasting is implicit between the first instance and Court of Appeal judgments in *LB v. Croydon District Health Authority*,²⁰⁷ where the tension between the court's urge to secure the public interest in saving lives and the need to make findings about individual competency was next tested:

LB was a young woman of 24, who had been abused as a child and now suffered a personality disorder, which was expressed in a pattern of self-harming behaviour. Restrained in hospital, without access to any implements by which she may cause herself injury, LB instead denied herself food. Her physical health deteriorated to the point where the medical team wanted to tube-feed her. LB applied to court for a declaration that she should not be medically fed against her will. The immediate crisis was averted when LB started to eat voluntarily again, but the proceedings continued because both the Health Authority and the patient wanted to know the legal position, in case the same situation arose again.

The background causes to LB's condition, and the behaviour she adopted as a coping mechanism, were distressing but this was compounded by a woeful failure of the system to offer her the only treatment which really offered any hope of improving her condition, namely psychotherapy. Treatment by tube-feeding was the equivalent of applying sticking plaster to an ulcerated wound; and any form of compulsion merely compounded the sense of abuse.

In that context, Thorpe J was unusually sensitive to the psychological effect on the patient of a finding of incapacity. He determined that LB had capacity to carry out all three stages of the decision-making process that led to refusal of

²⁰⁷ [1995] 1 FCR 332

food. In case that conclusion was questioned²⁰⁸ (as he must have known it was likely to be) he also made an alternative finding that, if she lacked the necessary competence, tube-feeding would not be in her best interests unless her physical state became so low as to threaten survival.²⁰⁹ At common law, therefore, Thorpe J's decision would have allowed the patient her autonomy, precisely up to the point where the public interest in preserving life came into play, and no further.

The Court of Appeal would not have been so generous. Although they made no decision on capacity, Hoffmann LJ expressed doubts²¹⁰ about Thorpe J's finding, with which Neill LJ²¹¹ agreed: he

“found it hard to accept that someone who acknowledges that in refusing food at the critical time she did not appreciate the extent to which she was hazarding her life, was crying inside for help but unable to break out of the routine of punishing herself, could be said to be capable of making a true choice as to whether or not to eat.”

There is force in these concerns, but also unnecessary cruelty to the patient. In his overall determination of the case, Thorpe J achieved a result which was endorsed by the Court of Appeal, without dealing the patient such a blow. His order empowered the Health Authority to force feed LB in extremis, but also empowered LB (a critical factor in the care of self-harming victims of abuse), with the hope that the extreme situation would therefore not be reached.²¹²

²⁰⁸ The Health Authority cross-appealed against the findings on capacity, but determination by the Court of Appeal was not necessary because the main appeal failed.

²⁰⁹ The reasons he gave for this conclusion were “First, the refusal is an expression of the patient's core personality. Second, the treatment would inevitably be regarded by the patient as a repetition in adult life of the invasive abuse suffered in childhood. Third, the consequence of treatment would be to magnify the disorder and thus further reduce the already poor prognosis for the only recognized treatment...Fourth, the patient is driven to her current position by a restrictive caring regime and by the absence of any present or proposed treatment plan.” (p344)

²¹⁰ At page 140

²¹¹ At pg142.

²¹² Such an interpretation of Thorpe J's decision is supported both by the reasons he gave (see footnote 24) and by his damning statements about the lack of treatment plan and poor prognosis even if appropriate therapy was provided.

The Court of Appeal did not have to make a finding on the question of capacity because the case was centred on statutory provisions, since LB was detained under the Mental Health Act. Section 63 of that Act dispenses with the requirement of consent of the detained patient in respect of treatment given for the mental disorder from which she is suffering.²¹³ Both courts accepted both that tube-feeding fell within the definition of ‘treatment’,²¹⁴ and that it was to be administered to LB in connection with her mental disorder.²¹⁵ Therefore, the Health Authority did not have to prove her lack of capacity. “Statute ...legalize(d) what the common law would not.”²¹⁶

Thorpe J found this “disquieting,”²¹⁷ and his declarations²¹⁸ operated to limit the power of the doctors. When s63 removed the need for consent, the only constraint on the doctors was their professional obligation to treat the patient according to her best interests; and Thorpe J limited that to life-saving situations.²¹⁹ His is a notably humane judgment, fully expressive of his experience as a judge of the Family Division. By comparison, the Court of Appeal’s greater willingness to dismiss LB’s capacity suggests not just a deference to statute, but a wider judicial tendency to honour the principle of a

²¹³ As long as it is given by or under the direction of the Responsible Medical Officer.

²¹⁴ At p 345: “Naso-gastric feeding is a medical procedure which, in my judgment, could not possibly be said to fall outside the broad band of ‘care under medical supervision’.”

²¹⁵ The connection between the treatment under consideration and the mental disorder may be indirect and the treatment still fall within the authority of s63. For example, in *Tameside & Glossop Acute Services Trust v. CH* [1996] 1 FLR 762, the schizophrenic patient had a delusional belief that obstetric advice would be harmful to her baby. In the circumstance, treatment by Caesarean section was declared lawful pursuant to s63.

²¹⁶ Thorpe J at p 345

²¹⁷ And so it is, as this case demonstrated: where “the basis for detention is borderline personality disorder, where the patient does not lack capacity, where, save in extreme circumstances, to impose treatment would not be in the patient’s best interests” (p345), the effect of the statute is extremely draconian and illiberal. Thorpe J found some comfort in the Code of Practice – an advisory document which s118 of the statute obliges the Secretary of State to prepare for the guidance of medical professionals, and which requires (at least in its extant form, which the Secretary of State has powers to revise) medical professionals to seek consent from patients with capacity, even if the treatment falls within s63. In truth the comfort to be drawn from this is thin, for the Code is nothing more than aspirational.

²¹⁸ That ‘tube feeding for the purpose of saving LB’s life and/or alleviating symptoms of starvation would be medical treatment for her disorder within the meaning of s63.’

²¹⁹ It is fair to point out that Thorpe J’s assessment of LB’s best interests went further towards meeting her wishes –and therefore was more respectful of autonomy – than did the doctors’, but it was still limited by the urge to protect the public interest in preserving life. He decided this case only 2 years (12th May 1992 to 20th July 1994) after he had decided the case of *Re W* in respect of an anorexic teenager. There too his generous findings of capacity were circumvented, by precedent which allowed him to override refusal and approve treatment ‘in the patient’s best interests’.

right to refuse treatment more in avoidance than observance. When a proposed treatment offers to save life, refusal of it can easily be seen as evidence of incapacity to decide.

Whose life is it anyway?: Nor is it only the life of the *patient* which invites lip-service to autonomy, as the viable pregnancy cases reveal. In each case, the court decision secured successful delivery of the baby, at the expense of negative findings of maternal capacity:

*Norfolk & Norwich Healthcare Trust v. W*²²⁰ : W arrived at the hospital in labour but denying that she was pregnant. The obstetrician sought authority to end the labour by means of forceps delivery or Caesarean section if necessary. Johnson J determined that, whether or not she was capable of comprehending, retaining and believing information about treatment, W was not able to balance the information given to her, and therefore lacked competence; and that termination of the labour would be in her best interests, in protecting both her physical health from the dangers of carrying a dead foetus and her mental health from the feelings of guilt if, by her refusal to consent, she caused its death.

Johnson J interrupted the hearing in the *Norfolk & Norwich* case to determine a similar application, in which there was just fifteen minutes left before intervention would be too late to save lives:

*Rochdale Healthcare (NHS Trust) v. C.*²²¹ The patient had negative previous experience of Caesarean, and said that she would rather die than have another. The obstetrician's opinion was that her capacity was not in doubt, but the Judge determined that a patient who could speak in terms which seemed to accept the inevitability of her own death was not able properly to weigh up considerations so as to make

²²⁰ [1996] 2 FLR 613

²²¹ [1997] 1 FCR 274

a valid decision, and the proposed intervention in labour was in her best interests for the same reasons as given in *Norfolk & Norwich*.

The other two cases came before different judges:

*Re L (Patient: Non-consensual Treatment)*²²² : The patient agreed to Caesarean delivery in principle but could not consent to the necessary anaesthesia because of a needle phobia. Kirkwood J determined that the phobia amounted to an involuntary compulsion which rendered her incapable of weighing relevant treatment information, and she therefore lacked capacity.

*Re MB (Medical Treatment)*²²³ : The Court of Appeal confirmed Hollis J's declarations of lawfulness where the patient's needle phobia caused her to panic and withdraw consent to Caesarean section. (Having the advantage of consideration without the time pressure of medical emergency, the appeal court also seized the opportunity to provide guidance for future cases.²²⁴)

On every occasion the court was at pains to express itself concerned exclusively with the interests of the woman herself,²²⁵ and avoid any consideration of foetal interests. But, no matter how clear the law is, judges are human beings, and the ethical dilemma of a viable foetus remains.²²⁶ The desire to secure safe delivery of the child demonstrably had an effect on the court's decisions as to capacity.

²²² [1997] 2 FLR 837

²²³ [1997] 2 FLR 426

²²⁴ For an interesting critique of how the Court of Appeal, in upholding Hollis J's decisions on the facts, actually failed to live up to their own guidelines see Michalowski, 'Court-Authorised Caesarean Sections – The End of a Trend?' [1999] Modern Law Review 115.

²²⁵ Johnson J even made this explicit in *Norfolk & Norwich* at p616: "Throughout this judgment I have referred to 'the foetus' because I wished to emphasise that the focus of my judicial attention was upon the interests of the patient herself and not upon the interests of the foetus which she bore." The Court of Appeal in *Re MB* unequivocally rejected any jurisdiction to take the interests of the foetus into account, even though the ratio of decision did not require such a statement.

²²⁶ As the Court of Appeal pointed out in *Re MB* at p440.

Johnson J expressly acknowledged the reality²²⁷ behind his legal language in one case, and happily related the actual outcome of the case in the other,²²⁸ accepting the woman's capacity to *consent* to the treatment he had approved without the slightest hint of irony.²²⁹ Kirkwood J began her deferred judgment with the mother's expression of delight at the outcome of a healthy baby,²³⁰ as if it were *ex post facto* justification of the court's decision – which the fourth case shows it truly to be, because in that case, the patient was *not* delighted at the outcome, and sued for damages:

*St. George's Healthcare NHS Trust v. S*²³¹ : MS consulted a GP when 36 weeks pregnant and was found to be suffering from pre-eclampsia. She was advised that both her own and the baby's life would be at risk unless the baby was delivered urgently, but she rejected that advice because she wanted a natural birth. The GP arranged for her to be seen by an Approved²³² Social Worker, who arranged for MS to be detained in Springfield, a mental hospital, under s2 of the Mental Health Act. She was transferred to a general hospital, St George's, where she continued to refuse consent to treatment. Hogg J granted St George's *ex parte* application for a declaration dispensing with the need for consent for Caesarean section.

In the perceived need for speed, significant mistakes were made – all against the interest of the patient as an autonomous adult. The judge was never told that S had instructed solicitors, or that she and they were ignorant of the legal proceedings. Counsel misinformed the judge that S had been in labour for 24

²²⁷ He continued, after the sentence quoted in footnote 219, "However, the reality was that the foetus was a fully formed child, capable of normal life if only it could be delivered from the mother."

²²⁸ "...in the time it had taken to come to court, the patient had changed her mind and given her consent to the procedure": *Rochdale Healthcare NHS Trust v. C* [1997] 1 FCR 274 at p 276

²²⁹ Empirical evidence supports the suspicion that medical professionals frequently do not question capacity when the decision accords with their recommendation: see Raymont et al, 'Prevalence of Mental Incapacity in Medical Patients and Associated Risk Factors: Cross Sectional Study' (2004) 364 *The Lancet* 1421.

²³⁰ *Re L* *ibid* at p 840

²³¹ [1999] *Fam* 26. (See previous discussion in the context of court jurisdiction)

²³² i.e. within the meaning of the Mental Health Acts.

hours. Other than drawing judicial attention to the admission under the Mental Health Act for assessment of her mental and psychiatric condition, which was still ‘ongoing’ and had as yet led to a diagnosis merely of ‘moderate depression’, the question of capacity to consent to medical treatment was not even considered. The judge did not ask about it; and Counsel did not volunteer the information that he had recently received a medical report which confirmed S’s capacity. The implication from the fact that the court exercised its powers at all would seem to be that S was simply assumed to lack competence. However there is some suggestion that the topic was not addressed at all because of the opposite assumption, namely that she was competent - but no one appreciated the fundamental importance of that fact.²³³ It is difficult to know which interpretation is worse! Either way, the fundamental disrespect for autonomous choice when life – or rather, *potential* life - is at stake could hardly be more clear.

Following the declarations, the baby was born healthily but initially rejected by the mother. M was returned to Springfield, where her detention under the Mental Health Act was terminated, and she discharged herself, without any specific treatment for mental disorder or mental illness ever having been prescribed. She went on to appeal against Hogg J’s declarations, and apply for judicial review of the decisions of the social worker and the hospital authorities.

A powerful Court of Appeal²³⁴ handed down a single judgment, granting both the appeal and the judicial review. Condemning all involved for a “fail[ure] to maintain the distinction between the urgent need of MS for treatment arising from her pregnancy and the separate question whether her mental disorder warranted her detention in hospital”, the Court of Appeal found the conclusion that detention was believed to be warranted in order to deal with MS’s pregnancy and the safety of her unborn child, “unavoidable.”²³⁵

²³³ per Judge LJ, handing down the judgment of the Court of Appeal, at p 41.

²³⁴ Comprising Butler-Sloss, Judge and Robert Walker LJ

²³⁵ At p57

The judgment strongly reinforced the theory of the autonomy of the pregnant woman. However in doing so, the Court of Appeal openly revealed the yawning gap between the higher courts, which expound legal doctrine, and everyone else, who has to apply it. The Court of Appeal had the luxury of contemplation in the abstract: no identifiable person was going to live or die according to their decision. MS had already recovered, and her baby was thriving. How much easier then to espouse lofty principle, than when faced – like the social worker, the doctors, and Hogg J - with a living individual whose unconventional decision risks not just her own life, but another being capable of independent existence? In truth, *their* response was guided by a different principle, namely the preservation of life, to which the autonomy of a pregnant woman fell easy victim. As Hogg J expressed it, “if the mother wishes to appeal this case, it means it has worked.”²³⁶

The Court of Appeal recognised the chasm – and implicitly accepted it without concern. When asked to consider the impact of an adverse judgment on the career of the social worker, the court expressed itself astonished by the very idea:

“At the very worst [adverse judgment] would mean that she had made a mistake that had taken volumes of papers, days of legal argument and the measured reflection of this court to identify. Whatever our conclusion we admire her courage in reaching any decision at all in such difficult circumstances when faced with a life and death situation and an unusual, unreasonable mother-to-be.....for humane reasons, she has erred in law.”²³⁷

This is not the swingeing criticism usually expected when public bodies act unlawfully, and when fundamental rights are infringed. Compensation in the form of damages was expected;²³⁸ but personal censure was not. Even whilst speaking the rhetoric of autonomy, the appeal court recognised the practical imperative of protectionism when life is at risk.

²³⁶ Quoted by Judge LJ at p 41.

²³⁷ At p53

²³⁸ See p62

The gap between law and facts: Acceptance of a shortfall between the holding of a legal principle and its translation into experience is simply realism. The gap exists – and will continue to exist – because medics are not lawyers. Their professional instinct is to approach these cases from a different direction. From a medical point of view, the starting point is treatment need; so doctors look at a patient’s decision, and measure it against their own assessment of best interests. Where they conflict, there is a tendency to question the ability to make the decision. Where there is an urgent call to save life, and little time for legal argument, courts of first instance do less irreparable damage by following the fundamental principle of preserving life: courts of *fact* behave like medics.

Only when there is time for consideration can a properly *legal* approach hold sway. Lawyers start with the principle of autonomy. They look at a patient’s decision, and measure it against the criteria of competency. When the judgment is about the rectitude of past or hypothetical future action – removed from the messy business of immediate consequences - the decision-maker is able to hold to their own view of best interests, and so find it easier to countenance the patient choosing something different. Courts of *law* behave like lawyers.

This conflict of approach, the impact it has on assessments of competence, and its effect on treatment decisions, were all vividly demonstrated in the case of *Re B (Adult: Refusal of Treatment)*²³⁹ :

B was an able and talented woman of 41, who had suffered a devastating illness which left her tetraplegic and kept alive by artificial ventilation. She wanted the ventilator to be switched off, claiming that it amounted to unlawful trespass as treatment without her consent. The court was asked to determine her capacity.

Butler-Sloss P went to the hospital to hear from B directly. Subject to the evidence of psychiatrists, she formed the view that B demonstrated “a very high

²³⁹ [2002] 2 FCR 1

standard of mental competence, intelligence and ability.”²⁴⁰ Five doctors gave evidence, all of them confirming the judge’s view. Drs. R and C, who were involved in B’s daily care, both accepted that she had capacity, but felt unable to comply with her wishes, because it felt like “being asked to kill”²⁴¹ her. Dr. G, a consultant surgeon unconnected with the treating team, accepted competence with the reservation that, without experience of life in a rehabilitation unit and in the community, B may not be fully informed.²⁴² Dr. I, a consultant psychiatrist unconnected with the treating team, recognised B’s competence, but also recognised that he had “looked throughout for reasons to demonstrate that she was *not* competent.”²⁴³ Dr. Sensky, instructed by the Official Solicitor, was so impressed by B that he placed her “at the extreme end of competence”.

Such overwhelming evidence of competence, when the relevant law is unambiguous, begs the question of why the matter had to go to court at all. As the evidence of the treating doctors demonstrated, it came down to a collision of expectation. For medics steeped in tradition of preserving life, a decision to end it, no matter how rational, was impossible to implement. The principles of autonomy and beneficence were in conflict, and the cold tenet of law asked too much of caring people who had formed a relationship with B.²⁴⁴ Even the judge was not unaffected. She, however, was able to separate her decision in respect of competency from its consequences.²⁴⁵ She ended her decision-making by returning the responsibility for consequences firmly to B, with something not far short of a plea to reconsider:

“...my decision leaves Ms. B with a future choice which she can consider freely now that she will be relieved of the burdens of

²⁴⁰ At para 53

²⁴¹ The evidence of Dr. C as set out in the judgment at para 57.

²⁴² The judge was not swayed by his reservation, observing that making decisions without direct experience of their consequences is a common feature of life; to expect otherwise would be unrealistic. (at p 63)

²⁴³ At para 71, italics added.

²⁴⁴ For B’s decision to be implemented it was accepted that she would have to be moved to a different hospital (probably an unprecedented event), who agreed to accept her from the outset on the basis of treating her according to her wishes. (Para 85)

²⁴⁵ “I am not asked directly to decide whether Ms. B lives or dies but whether she, herself, is legally competent to make that decision.” (para 12)

litigation. She is not bound by her past decision and when she goes to the hospital prepared to accept her, she has the right to reflect on what she may wish to do with her life. I would like to add how impressed I am with her as a person....I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large.”²⁴⁶

Conclusions: The cases dealing with assessments of adult competence demonstrate that, even whilst espousing the rhetoric of autonomy, wherever their decision has an immediate life-or-death effect, the courts follow a protectionist agenda. The capacity for autonomy is questioned, and often found wanting, simply by reason of the very condition which prompts its exercise. Even if capacity is admitted, its exercise is questioned. Has a decision really been made, does it extend to the actual circumstances in contemplation, and is it truly independent? They all offer the possibility for avoiding the consequences of an apparently autonomous choice. Only in circumstances of leisured and hypothetical argument has the court actually upheld the right to refuse treatment. Courts are gatekeepers to autonomous decision-making, and they manipulate assessments of capacity just as locksmiths cut keys, to protect adults from the consequences of their own decisions whenever those consequences flout judicial values.

Child Patients

The law starts from a different position in respect of child patients. Subject to statutory provision,²⁴⁷ they are assumed to lack capacity to consent to treatment by virtue of their minority. Their parents, acting in the child’s best interests, have the power to give or refuse consent;²⁴⁸ and the court steps in with a protective jurisdiction when parental decisions are challenged.

²⁴⁶ Para 95

²⁴⁷ Section 8 of the Family Law Reform Act 1969 provided that the consent to medical treatment of a person over the age of 16 will be valid. See earlier discussion on jurisdiction.

²⁴⁸ See earlier discussion of jurisdiction.

So long as children are obviously children, this approach is tolerably practicable, and cases come to court only when the medics disagree with the parents' opinion of best interests. However children grow up, and it's a process rather than an event. Most children demand, and most parents acknowledge, that the degree of control which parents exercise over the lives of their offspring recedes incrementally as they mature and develop the ability to make choices for themselves. Although young people gain legal majority on the day of their eighteenth birthday, and statutory recognition of their consent to treatment on their sixteenth birthday, in practice they will have been developing the skills of adulthood for some time before then. Between the incapacity of childhood and the autonomy of adulthood is an undefined time of borderline competence, when the limits of state paternalism and children's rights are tested.

The struggle for power - parents or children?: Judicial determination of capacity borderline by reason of age first came about as resolution of an implicit power struggle between parents and older children. The House of Lords determined (in both senses of the word²⁴⁹) the law, in the case of *Gillick v. West Norfolk & Wisbech AHA*²⁵⁰ :

Mrs. Gillick was the mother of 5 daughters under the age of 16. When the Department of Health issued to area health authorities guidance on family planning services which suggested that contraceptive advice and treatment could be given to children without parental consent, she sought an assurance from her local authority that no such treatment would be given to her daughters without her knowledge and agreement. When the health authority refused to give such assurances, she applied to court for a declaration that the guidance was unlawful.

²⁴⁹ The case both worked out what the law was, how it had developed and why, and set it on a new course for the future. In Lord Scarman's words, "This case is the beginning, not the conclusion, of a legal development in a field glimpsed by one or two judges in recent times...., but not yet fully explored."

²⁵⁰ [1986] AC 112

Considering the impact this case had on the future development of the law, it is worth noting that it was far from a unanimous decision. In the House of Lords itself, two speeches were in favour of Mrs. Gillick; of the majority, two speeches were detailed arguments in favour of the defendants, but on different reasoning, and the third simply a short averment purporting to agree with them both. Of the nine judges who considered the case, only four of them agreed with the ultimate outcome.

In the Court of Appeal, Mrs. Gillick won. The main issue for determination²⁵¹ was identified as “*the extent of a parent’s rights and duties with respect to medical treatment of a girl under 16.*”

(a) The leading judgment was given by **Parker LJ**, who determined that such parental rights and duties were complete and exhaustive, with no distinction between contraceptive and other types of medical advice. He found the suggestion of individual assessment over fixed age of capacity “singularly unattractive and impracticable, particularly in the context of medical treatment.”²⁵² He did draw some authority from *Re D*, equating contraception advice with sterilisation, and wardship with parenting, but the authorities he chiefly relied on were much older,²⁵³ and not concerned with medical treatment.

(b) **Fox LJ** followed broadly the same reasoning, but accepted that the older cases reflected “far too extreme” a notion of parental authority. He considered the possibility of a minor’s capacity to consent acting as a trump card, but rejected it as an unlikely direction for the law to take.²⁵⁴ Interestingly for

²⁵¹ The second issue was expressed as “the extent to which, if at all, the provisions of the criminal law assist in the determination of the extent of the parents’ rights and duties in relation specifically to contraceptive and abortion advice and treatment.” Per Parker LJ at p122

²⁵² At p 124

²⁵³ *R v. Howes (1860) 3 E & E 332*, and *Re Agar-Ellis [1883] 24 Ch.D 317*

²⁵⁴ At p144. Without thought of continuing progression of common law, the authorities which he found to display no such tendency were the very ones (n52) he had earlier rejected.

children's autonomy, his closing comments indicate a view of best interests which takes no account of children's own views at all.²⁵⁵

(c) **Eveleigh LJ** took it simply as a matter of "common sense"²⁵⁶ that decision-making power rested with the person having custody of the child unless displaced by the child's welfare. Only in cases that would be "extremely rare and almost impossible to conceive when the parents are thoroughly responsible people"²⁵⁷ would it be permissible to act in spite of parental wishes.

When the case reached the House of Lords,

(a) **Lord Fraser** split the issue into two distinct questions, and reversed the order of importance:²⁵⁸

- (1) whether a girl under the age of 16 has the legal capacity to give valid consent to contraceptive advice and treatment including medical examination;
- (2) whether giving such advice and treatment to a girl under 16 without her parents' consent infringes the parents' rights.

His positive conclusion on the first issue was almost cursory.²⁵⁹ On the extent of custodial rights, he flatly rejected the insistence on a fixed age as "contrary

²⁵⁵ At p145, "I would not, in any way, wish to underrate the value of the part which an experienced doctor can play in the practical resolution of the problems with which we are concerned. Nor should one underrate the parents' part. They know the child and its history. In most cases, whatever the law may be, the best outcome is likely to be that which is the consequence of full co-operation between the parents and the doctor in deciding what is in the child's best interests."

²⁵⁶ At p146

²⁵⁷ At p149

²⁵⁸ Per Lord Fraser at p166

²⁵⁹ He dismissed every one of the statutes relied on in the Court of Appeal, both individually and collectively. His view was that s8 Family Law Reform Act 1969 left open the question of whether the consent of a minor under 16 had ever been valid before; that NHS Regulations do not show that a minor under 16 cannot appoint a doctor, only that someone else *may* do it on his behalf; that the Mental Health Act is of only remote relevance since it is not in dispute that a child under 16 is in the custody of his parents – the question is rather the extent of the custody powers; and the Education Act puts no obstacle in the way of a minor seeking treatment without the encouragement of the education authority. "It seems to me verging on the absurd to suggest

to the ordinary experience of mankind, at least in Western Europe in the present century.”²⁶⁰

Coming down in favour of a welfare-based solution, he slips from a general confidence that “important medical treatment of a child under 16 would normally only be carried out with the parents’ approval”²⁶¹ to a *specific consideration* of contraceptive treatment. The practical risks of driving girls away from seeking advice lead him to conclude that a doctor may treat without parental consent IF he is satisfied of basic prerequisites.²⁶² He found “nothing strange”²⁶³ in leaving such wide non-clinical discretion in the hands of doctors, and regarded any consideration of criminal law as irrelevant because doctors treating within his guidelines would lack any criminal intent.²⁶⁴

(b) **Lord Scarman** reduced the issue to a single question.²⁶⁵ He found in the development of the common law a principle that parental rights are derived from parental duties and exist only as long as is necessary for the protection of the child.²⁶⁶ When a child reaches sufficient understanding and intelligence to be able to capable of making up his own mind, parental right yields.²⁶⁷

that a girl or boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set....I am not disposed to hold now, for the first time, that a girl aged less than 16 lacks the power to give valid consent to contraceptive advice and treatment, merely on account of her age.” (p169)

²⁶⁰ At p171: “in practice most wise parents relax their control gradually as the child develops and encourage him or her to become increasingly independent. Moreover, the degree of parental control actually exercised over a particular child does in practice vary considerably according to his understanding and intelligence and it would, in my opinion, be unrealistic for the courts not to recognise these facts.”

²⁶¹ At p173

²⁶² Namely that the girl will understand his advice; that he cannot persuade her either to inform her parents or to allow him to do so; that she is very likely to begin or continue to have sexual intercourse with or without contraceptive treatment; that unless she receives treatment her physical or mental health, or both, are likely to suffer; and that her best interests require it.

²⁶³ At p174

²⁶⁴ At p175

²⁶⁵ At p181: “Can a doctor in any circumstances lawfully prescribe contraception for a girl under 16 without the knowledge and consent of her parents?”

²⁶⁶ P184

²⁶⁷ P186

Inherent lack of certainty is simply “the price which has to be paid to keep the law in line with social experience.”²⁶⁸ For him the principle is of general application, and contraceptive treatment merely one instance of its application, and the responsibility vested in doctors is acceptable because theirs is “a learned and highly trained profession regulated by statute and governed by a strict ethical code.”²⁶⁹

So, Lord Fraser’s vision was of parental rights ceding to doctors’ right to act in the best interests of their patients on the narrow issue of contraceptive treatment; and Lord Scarman’s vision was a much wider one of parental rights ceding to the child’s. **Lord Bridge** declared himself in agreement with both of them!

At least the dissenting judgments managed better consistency, both turning on the specific treatment in issue:

(c) **Lord Brandon** considered that provision of contraceptive advice and treatment to girls under the age of consent to sexual intercourse amounted to promoting, encouraging or facilitating an offence, was probably itself an offence, and was in any event contrary to public policy. For him, the issue of parental rights simply did not arise.

(d) **Lord Templeman** did not consider the provision of contraceptive treatment to be criminal as long as it was supported by appropriate consent, but criminal law was at the root of his conclusion that such consent would have to be from a parent. In providing that consent did not afford a defence to a man charged under s6 of the Sexual Offences Act 1956, he concluded, Parliament had indicated that a girl under 16 lacked sufficient maturity to decide a question of contraception.

On the wider principle of children’s developing autonomy, there was also a surprising degree of accord. Lord Templeman simply considered that whether

²⁶⁸ P191

²⁶⁹ P190

consent of a child under 16 was valid would depend on the nature of the treatment, and the age and understanding of the patient²⁷⁰ - with the clear implication that a child's consent to some treatments *would* be valid. Lord Brandon's views in the context of less controversial forms of treatment are not categorically stated but a tantalising glimpse into what they may have been appears from the other judges quoting his decision in *R. v. D.*²⁷¹ Although Parker LJ had distinguished it as a criminal law case, Lord Scarman²⁷² relied on it as acceptance of developing autonomy in preference to legal pre-determination of age.

So taken all together, notwithstanding disagreement on the particular treatment in issue, the judgments of the House of Lords clearly reject the detailed casuistry of the Court of Appeal, and adopt instead a more generous interpretation of developing autonomy, based on pragmatic reality.²⁷³

Superficially, *Gillick* seems to be a blow to the quest for *family* involvement in medical decision-making in respect of young people: the court endorsed individualism even of minors otherwise totally dependent - financially, educationally, for housing, feeding and clothing - on their parents. However, the factual nexus of the case suggests that such an interpretation is unduly pessimistic.

The prerequisites of Lord Fraser and Lord Scarman are particularly important in this context: before a doctor can treat in the absence of parental consent, he has

²⁷⁰ P201

²⁷¹ [1984] AC 778

²⁷² At p 188

²⁷³ At the real life effects of the Court of Appeal decision was made obvious to the House of Lords. It was later summarised by Silber J in *R(Axon) v. Sec. St. for Health* [2006] EWHC 37: "In the period between the decision of the Court of Appeal in the *Gillick* case and that of the House of Lords, during which medical professionals were required to pass on information to children's parents, the number of young women aged under 16 who sought advice on contraception fell from 1.7 per resident thousand to 1.2 per resident thousand, which was a striking and disturbing reduction of just under one-third. In addition, the rates of attendance at places where contraception advice and treatment were given did not return until 1988-1989 (or until 1990 according to the Brook Organisation, the charity providing free confidential sexual health advice to under 25s) to their previous levels prior to the Court of Appeal decision in 1984. These statistics provide clear and powerful evidence of what happens when young people are not assured of confidentiality when they are considering obtaining advice and treatment on sexual matters."

to try to persuade the young person to involve their parents. If that fails, the doctor must still be convinced that his patient is capable of understanding medical advice independently – that she has reached intellectual maturity. These prerequisites suggest that the House of Lords was more supportive of a family role than first impressions may have suggested. In truth, the House of Lords decision in *Gillick* says more about our cultural attitude to teenagers and the way they progress to adulthood – sexually before financially – than it does about wider issues of family involvement in healthcare decision-making.

The struggle for power - children or courts? : In protecting burgeoning juvenile autonomy from overbearing parental authority, the seeds are also sown for the restriction of the court's own protective powers. If a child is autonomous vis-à-vis her parents, that same autonomy should also (in solidarity to the rights recognised for adults) restrict the powers of the court to impose its own view of best interests. As a result, *Gillick's* generous interpretation of developing autonomy was soon found to cause the courts problems. Autonomy implies that decisions can be made with which others disagree. If minors are afforded the ability to make treatment decisions, how can the courts avoid decisions with which they do not agree– those which offend the first judicial preference - and protect young people from themselves?

In the case of *Re E (A Minor)(Wardship: Medical Treatment)*²⁷⁴ E was less than 3 months short of his 16th birthday. Thirteen days before the court hearing he had been diagnosed with leukaemia. Immediate treatment with blood products offered an 80-90% chance of cure, but E and his family were Jehovah's Witnesses, who did not consent to the use of blood products. The chances of cure by other treatments were reduced to 60%. Medics initially followed the riskier course, but E's condition deteriorated so the hospital applied to court for leave to treat E as they considered necessary. The court spent ten hours dealing with the case, finally giving judgment at around midnight, by which time it was just hours, or at most a day, before E's condition would become critical.

²⁷⁴ [1993] 1 FLR 386

The problem arose not because of any doubt that E could give a valid consent to treatment,²⁷⁵ but because he (and his parents) *refused* it. It is worth noting that there is a qualitative difference between consent to and refusal of treatment. Overriding consent simply means that no treatment is given, and the status quo continues. Overriding a refusal is a more confrontational interference with autonomy, both intellectually and physically. It requires forcing something on the patient. One might therefore expect even greater circumspection before countenancing it.²⁷⁶

Ward J was “impressed” by E’s “obvious intelligence, by his calm discussion of the implications, by his assertion even that he would refuse well knowing that he may die as a result”; and he found that E was “of sufficient intelligence to be able to take decisions about his own well-being”. Yet none of this was sufficient, because the decision E made would lead to his unnecessary death, and therefore contravened the first judicial preference. The court solution was to set the threshold of understanding necessary for a finding of *Gillick* competence extremely high. The judge concluded that E did “not have a full understanding of the whole implication of what the refusal of that treatment involves,”²⁷⁷ meaning the painful process of death which E would have to endure, and the distress which his parents would be caused. “..[H]e has not the ability to turn his mind to it, nor the will to do so. Who can blame him for that?”²⁷⁸

This approach amounts to overt, unapologetic protectionism. It is in striking contrast to Butler-Sloss P’s clear acceptance that adults make decisions without full experience of their consequences.²⁷⁹ The threshold of competence was manipulated to retain for the court the ability to impose its own ability of best

²⁷⁵ Had E’s views coincided with the medical view, it is extremely doubtful whether his competence to consent would ever have been questioned.

²⁷⁶ Ward J did indeed consider the practical effect of granting the application, at p 394: “I find that E will protest, but I have no evidence before me which satisfies me that he will carry his protest to the point of pulling out the tubes or fighting the doctors as they endeavour to insert them or smashing the blood bags above his bed. On the contrary I find that, although he will protest, at the end of the day he will respect the decision of this court.”

²⁷⁷ At p 385

²⁷⁸ At p385.

²⁷⁹ See n241 above. Even if E could not turn his mind to these matters, his parents presumably had such understanding, or could be given it. Their refusal was overridden as well.

interests on the patient. The hurdles that teenager E would have had to jump to be allowed to determine his own best interests were simply set higher than those for patient just a few months older.

E's parents were alluding to this when they argued that it would be wrong for the court to intervene when E was "so close to his 16th birthday"²⁸⁰ – someone within three months of having a legally recognised right to consent, should be treated *as if* they had already achieved it.²⁸¹ Their argument was very much in the spirit of *Gillick*²⁸² but its relevance lay in the unspoken assumption that the statutory right to consent to treatment carried with it also its opposite, the right to refuse. Such is the power of the protectionist urge, Ward J ignored completely the "almost there" argument. As soon as the court got the opportunity, it also shattered the assumption that consent and refusal of minors are but mirror-images of each other.

In *Re R (A Minor)(Wardship: Consent to Treatment)*,²⁸³ R was just two months short of 16, and in the care of the Local Authority. She suffered episodes of mental illness characterised by violent and suicidal behaviour. She was detained under the Mental Health Act, and admitted to an adolescent psychiatric unit, where the proposed treatment was compulsory administration of anti-psychotic drugs, to which the Local Authority initially consented. Later that same evening in a lucid conversation with her social worker, R indicated that she would refuse treatment. The Local Authority therefore withdrew its consent and applied for wardship, with leave to administer the medication. The Consultant Psychiatrist gave evidence that without treatment R would soon lapse into psychotic state, but between episodes she sufficiently understood the nature of the illness and the treatment to be competent to give or refuse consent.

²⁸⁰ Submission of Counsel for E's parents, quoted at p398.

²⁸¹ In fact, when he did reach adulthood, E continued to refuse treatment with blood products. Without the wardship jurisdiction, and with no realistic argument of incapacity, the medics were then bound by his refusal, and he died. (As told by his Counsel to Johnson J in *Re S (Minor)(Consent to Medical Treatment)* [1994] 2 FLR 1065 at 1075). This real-life litmus test of judicial protectionism case played on the judge's mind in the later case of *Re P (Minor)(Medical Treatment: Best Interests)* [2003] EWHC 2327

²⁸² And exactly the kind of argument that Parker LJ in particular had worried about!

²⁸³ [1991] 3 WLR 592

Waite J considered that the court lacked power to override the refusal of a competent minor. However, he found as a fact that R's condition precluded her from "competence". Considering the proposed treatment to be in her best interests, he granted permission for it to be administered against her will. How much was his assessment of R's competence influenced by his clear preference for treatment, and the need for a court jurisdiction to impose it?

When the Official Solicitor appealed on R's behalf, the Court of Appeal agreed with Waite J that she lacked competence, by reason of her fluctuating mental state,²⁸⁴ rather than her age. Given that R had lucid periods, as Douglas points out,²⁸⁵ it would have been more honest to justify enforced treatment on the basis of Mental Health Act powers, than under common law powers more properly related to competence by virtue of age, but up to this point the ratio of the case is unexceptional, and commentators would probably have been prepared to accept it.²⁸⁶ Similarly, it was uncontroversial²⁸⁷ when the Court of Appeal asserted unanimously that their powers in wardship went beyond parental powers. What caused concern was the Court of Appeal's determination that there was power to override the refusal of a competent minor, its apparent willingness actually to use such power, and Lord Donaldson's restrictive interpretation of *Gillick*.

²⁸⁴ Per Farquahrsen LJ at p31: "We are not here solely concerned with the developing maturity of a 15- year-old child but with the impact of a mental illness upon her. The *Gillick* test is not apt to a situation where the understanding and capacity of a child varies from day to day according to the effect of her illness. I would reject the application of the *Gillick* tests to an on/off situation of that kind."; and per Lord Donaldson at p 25, "...there is no suggestion that the extent of this competence can fluctuate upon a day to day or week to week basis. What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age, but even this test needs to be modified in the case of fluctuating mental disability to take account of that misfortune." Such a view stands in stark contrast to the approach subsequently adopted in the Mental Capacity Act 2005 (see later), which lends support to the argument of Douglas noted at 87 below.

²⁸⁵ Gillian Douglas, '*The Retreat from Gillick*' MLR [1992] 55(4) 569 – 576 at p 572. The reluctance to use Mental Health Act powers on minors is usually explained as a reluctance to stigmatise the child. The UK government explicitly used such an argument in the context of compliant adults too when the *Bournewood* litigation reached the European court (see following chapter). Such an attitude to Mental Health Act powers is self-fulfilling: the more we avoid them as stigmatising, the more a stigmatising attitude is endorsed. Moreover, what could be more damning to an adolescent than to tell them they have failed to outgrow the competence of a child?

²⁸⁶ See for example, Andrew Bainham, in '*The Judge and the Competent Minor*' LQR 1992 108 (Apr) 194 – 200 at p 200; Lynn Hagger in '*Some Implications of the Human Rights Act 1998 for the Medical Treatment of Children*' Med. L. Int 2003 6(1) 25 -51 at p29; and even Gillian Douglas *ibid*.

²⁸⁷ See earlier discussion on jurisdiction. Bainham, *ibid* p196, could "readily accept" that the court had "technical jurisdiction" to override the wishes of a competent minor.

The distraction of distinguishing consent and refusal: James Munby QC had put the argument for R and the Official Solicitor explicitly on the basis of the fundamental principle of autonomy,²⁸⁸ implying that consent and refusal are simply opposite sides of the same legal concept, and should be afforded equal respect. Lord Donaldson was not impressed. Effectively he dismissed again any application of the autonomy principle to minors, by undercutting the power of consent so recently won:

“...consent....is merely a key which unlocks a door. Furthermore, whilst in the case of an adult of full capacity there will usually only be one keyholder, namely the patient, in the ordinary family unit where a young child is the patient there will be two keyholders, namely the parents, with a several as well as a joint right to turn the key and unlock the door. If the parents disagree, one consenting and the other refusing, the doctor will be presented with a professional and ethical, but not with a legal, problem because, if he has the consent of one authorised person, treatment will not without more constitute a trespass or a criminal assault.”²⁸⁹

Lord Donaldson interpreted the final *Gillick* decision as authorising a competent minor to become a dual “keyholder” concurrently with her parents, rather than taking control of the only key.²⁹⁰ He envisaged the possibility of dual keyholders taking opposing views, and neither of them being decisive, and in so far as the

²⁸⁸ At p14: “Legal policy gives effect to the libertarian principle that the individual has the right to determine what is done to his own body and that no one else may decide what is done to it even on the ground that it is for his benefit: see *On Liberty* 2nd Ed. (1859) ch1 pp7-30, by John Stuart Mill....That policy constitutes the law’s acknowledgment that paternalism, in the sense of determining what is objectively good for another, has no place in this branch of law.”

²⁸⁹ At p22.

²⁹⁰ See p23: “I do not understand Lord Scarman to be saying that, if a child was ‘*Gillick* competent’...the parents ceased to have an independent right of consent as contrasted with ceasing to have the right of determination, that is, a veto. In a case in which the ‘*Gillick* competent’ child refuses treatment, but the parents consent, that consent *enables* treatment to be undertaken lawfully, but in no way determines that the child shall be so treated. In a case in which the positions are reversed, it is the child’s consent which is the enabling factor and again the parents’ refusal is not determinative.”

House of Lords had said anything different, he curtly disregarded that as “obiter” and “wrong.”²⁹¹

This interpretation strains the spirit of the House of Lords decision in *Gillick* to the limit,²⁹² and feels like an overruled judge still smarting from the experience.²⁹³ Andrew Bainham has three fundamental objections²⁹⁴ to concurrent keyholding, but the first of them is that it can only work on the assumption that the doctor is dealing solely with the parent or solely with the child, and is unaware of disagreement. This may be the case where the competent minor is, for example, unconscious, but is clearly not going to be the case where the issue is administration of drugs such as to R. Bainham is right to highlight the dilemma for medics, but he overlooks the more important implication, that their difficulty is society’s. Put another way, if neither parent nor competent child has determinative power, then who does?

Lord Donaldson did not offer an explicit answer, but the logical implication of concurrent keyholding must be that the doctor could lawfully follow which ever course he personally preferred²⁹⁵ – a highly questionable extension of medical discretion, a backward step from the principle of autonomy, and a serious

²⁹¹ “If Lord Scarman intended to go further than this and to say that in the case of a ‘*Gillick* competent’ child, a parent has no right either to consent or to refuse consent, his remarks were *obiter*, because the only question I issue was Mrs. Gillick’s alleged right of veto. Furthermore I consider that they would have been wrong.” P23

²⁹² As even was acknowledged within the court by Staughton LJ, who declined to offer an opinion but saw this as a difference of view between Lord Donaldson and Lord Scarman – p27. Commentators agreed. As Andrew Bainham put it, *ibid* p194, “No one doubted that Lord Scarman..was according priority to the competent child’s wishes where those clashed with the parents’ views – no one, that is, except apparently the Master of the Rolls.”

²⁹³ Lord Donaldson’s judicial career was often controversial and publicly criticized, for example his handling of the NIRC and the Maguire IRA trials. He clearly felt strongly about the issues involved in *Gillick* and *Re E*, both decisions which attracted strong criticism. In September 1992, just three months after refusing another appeal against his view of the law in *Re W*, he chose to retire early.

²⁹⁴ The other two are (a) that it flies in the face of the settled interpretation of s8 (1) Family Law Reform Act 1969 (although in fact it is doubtful whether there ever really was any “settled interpretation” of s8. When Balcombe LJ in *Re W (A Minor)(Medical Treatment: Court’s Jurisdiction)* [1992] 3 WLR 758 at p 86 invited Counsel to refer him to any cases other than *Gillick* which settled the interpretation of the section, they were unable to find any.); and (b) that it turns the clock back from *Gillick*, where the House of Lords gave clear precedence to the views of the competent child.

²⁹⁵ Although when actually placed in the position of making the decision, because although her parents consented, a 15 year old girl refused to consent to heart transplant, the doctors in *Re M (Child: Refusal of Medical Treatment)* [1999] 2 FCR 577 preferred to refer the matter to court. It is of course impossible to know whether medics are always so scrupulous.

impediment to the supportive functioning of patients and families. Concern about the power this approach vests in doctors is simply exacerbated by a close reading of the background facts of the case: consideration was first given to compulsory medication because R “was becoming increasingly defiant,”²⁹⁶ and the unit would only accept R as a patient if it had “an entirely free hand in regard to the administration of medication to her, whether she was willing or not.”²⁹⁷ The lack of judicial challenge²⁹⁸ to these factors colludes in a possibility of treatment for the patient management needs of *institutional* carers.²⁹⁹ Any interpretation of borderline capacity which exacerbates this tendency must be regrettable, because of the threat it represents to the liberty of us all.

Inevitably, this interpretation of the law was challenged at the earliest opportunity. With the advantage of statute firmly on her side on the question of consent, in *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)*,³⁰⁰ a 16 year old girl asserted an equal and opposite right to refuse treatment. She was in Local Authority care because her parents had both died, and was admitted to a residential unit suffering anorexia. The Local Authority wanted to transfer her to a specialist eating disorder unit, against her wishes.

Opting for separate representation, W argued that s8 FLRA gave her the same right as an adult to refuse treatment, specifically claiming that Lord Donaldson was wrong. The OS remained as *amicus curiae* and argued the same point. Thorpe J, constrained by the doctrine of precedent, had little room for manoeuvre. Although he did make a clear finding that W had sufficient understanding to make an informed decision, he said the court could authorise treatment without her consent (and gave leave for appeal). Whilst the appeal was pending, W’s condition deteriorated markedly. W’s hopes of success probably sank as soon as Lord Donaldson was given the case, but on this

²⁹⁶ Per the senior registrar and director of child psychiatry at the unit where R was placed, at p19.

²⁹⁷ Described by Lord Donaldson at p20.

²⁹⁸ Farquharson is resigned to powerlessness in effect: at p30 he says “the decision of this court will have little impact, as she is likely to be subjected to the medication whether the appeal succeeds or not. If Waite J’s decision is upheld...she will be treated at the unit, otherwise she will receive the medication...at an adult hospital.

²⁹⁹ The determination not to yield in the same way to the needs of *family* carers is striking.

³⁰⁰ [1992] 3 WLR

occasion, he was fully supported by both the other members of the court, Balcombe and Nolan LJJ.

The Court of Appeal maintained the view of consent as a legal³⁰¹ device protective of doctors rather than patients: “the legal purpose [of consent]...is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person.”³⁰² The key was transformed into a flak jacket,³⁰³ but it was clearly a white one, because there is no mention at all of the provision to patients of a defence to unwanted intrusions on their autonomy.

At first blush, the ‘flak jacket’ approach seems to be supportive of a decisive role for families in treatment disputes with young people. The argument that refusal of treatment by a 16 year old amounts to a veto, even if someone else with parental responsibilities consents, involves the proposition that the parent is deprived of the power of consent. The court’s response was a detailed exercise in statutory deconstruction. It pointed out that section 8 says no such thing, providing only that parental consent would be *unnecessary* - which is quite different to *ineffective*. Reference was even made to the Latey Report³⁰⁴ on which the Act was founded. Balcombe LJ fixed on the mischief which the report intended s8 to remedy;³⁰⁵ Lord Donaldson provided his own emphasis on the conclusion.³⁰⁶

³⁰¹ As opposed to clinical. “The *clinical* (italics added) purpose stems from the fact that in many instances the cooperation of the patient and the patient’s faith or at least confidence in the efficiency of treatment is a major factor contributing to the treatment’s success. Failure to obtain consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment. I appreciate that this purpose may not be served if consent is given on behalf of, rather than by, the patient.”

³⁰² Per Lord Donaldson at p76.

³⁰³ Per Lord Donaldson at p78.

³⁰⁴ The Report of the Committee on the Age of Majority, 1967, Cmnd 3342. The relevant part is contained in paragraphs 474 -484.

³⁰⁵ At p86: that “doctors felt difficulty in accepting the consent of someone under 21 (the then age of majority) to medical treatment, even though parental consent might be unobtainable or..undesirable”

³⁰⁶ At p78: “It recommended that: ‘*without prejudice to any consent that may otherwise be lawful*, the consent of young persons aged 16 and over....shall be as valid as the consent of a person of full age.’ (My emphasis)”

The conclusion that W's argument was wrong in law was compelling. It is less clear however, that the decision was in reality supportive of families. In truth, it was the *court's* keyholding role which was being protected, not the family's. *Re M (Child: Refusal of Medical Treatment)*³⁰⁷ illustrates the point: when the child refused treatment, but the parents consented, the doctors did not consider themselves protected by parental consent, but sought (and were granted) court approval.

However unimpeachable the statutory interpretation may have been in *Re W*, the failure of the court to question whether the power they found to exist should actually be used, or merely retained as a residual measure *in extremis* is a clear indication that the court was driven by a desire to protect its own jurisdiction, because it flies in the face of *Gillick*. All but one³⁰⁸ of the professional bodies which gave evidence to the Latey Committee had recommended that patients aged between 16 and 18 should also be able to give an effective refusal. More than 20 years of general social emancipation had gone by since the Latey Committee rejected their advice, and the *Gillick* decision would have provided unassailable grounds for limiting the use of power retained by statute³⁰⁹ – had the will existed. Instead, the protective urge prevailed, and it was *Gillick* that had to be restricted. As Nolan LJ³¹⁰ put it,

“...the present state of the law is that an individual who has reached the age of 18 is free to do with his life what he wishes, but it is the duty of the court to ensure so far as it can that children survive to attain that age.”

However courts do not exist in a social vacuum. The approach of the House of Lords in *Gillick* was more in tune with the times than were the subsequent

³⁰⁷ [1999] 2 FCR 577

³⁰⁸ The exception was the Medical Protection Society.

³⁰⁹ Judicial restriction on the use of statutory power is a common feature of our legal system. For example, the statutory scheme of schedule 1 of the Children Act 1989 was intended by the legislature to put the children of unmarried parents in the same financial position as children of married parents in the event of adult separation, but the courts have interpreted their powers much more restrictively.

³¹⁰ At p94.

attempts to restrict it. Whilst the Court of Appeal had been contending with nascent autonomy, so too had the legislature. The Children Act 1989, which came into effect in October 1991 between the decisions of *Re R* and *Re W*, included in s38(6) a child's right to refuse medical treatment. Seemingly, the expectations of the legislature and the courts were at odds.³¹¹ It was statute, not judicial precedent, which forced the court to acknowledge, as it did in the case of *South Glamorgan CC v. W & B*,³¹² that their powers to override the wishes of a competent minor should be used only as a measure of last resort.

The effect of limiting the court's power to override refusal: Restraint on the use of court power to override the refusals of competent minors proved not to invite the moral chaos which Lord Donaldson had feared, because courts had resort to other ways to preserve their authority, chiefly the power to determine competence. It took seven years for the law reports to accumulate the next three instances of court intervention³¹³ and all of them could easily be characterised as extreme, involving as they did life-or-death treatments, but the court did not dare to suggest that overriding refusal was being used as a measure of last resort. Instead, what really unites these cases is the court's assessment of competence – and in particular its absence. The *theory* of autonomy may have been invigorated, but the court was not obliged to watch youthful inexperience erode the public interest in preserving life because *in practice*, the court was able to avoid the theory simply by finding as a fact that competence was lacking.

³¹¹ Bainham, *ibid* p197, points out that *Re R* was in conflict with ss43(8), 44(7), 38(6) and sch.3 para 4(4) of the Children Act 1989, which provide that a child may refuse to submit to medical examination or psychiatric examination or treatment directed by the court, if the child has "sufficient understanding to make an informed decision". Against this he concedes that the tenor of the Children Act works against the notion that the views of the competent child are decisive. In most instances, the formula adopted in the legislation is to require decision-makers to ascertain and consider the wishes and feelings of children to an extent consistent with their age and understanding. The more powerful point is that refusal of medical treatment has therefore been singled out as different to the usual run of decisions on which children's views are considered.

³¹² [1993] 1 FLR 574. Douglas Brown J, "without any doubt", reiterated the power as Lord Donaldson had described it, and determined that the words of the statute at s100(2)(d) were insufficient to abrogate that power. The contrary intention of statute only limited its exercise. "In my judgment, the court can in an appropriate case – and they will be rare cases – but in an appropriate case, when other remedies of the Children Act have been used and exhausted and found not to bring about the desired result, can resort to other remedies." (p584)

³¹³ *Re S (A Minor)(Consent to Medical Treatment)* [1994] 2 FLR 1065, *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810, and *Re M (Child: Refusal of Medical Treatment)* [1999] 2 FCR 577.

In *Re M* the patient was fifteen and a half and refusing consent to a heart transplant. Johnson J considered that she was ‘overwhelmed by the circumstances and the decision she was being asked to take’. In *Re S* and *Re L* the patients were 15 and 14 respectively, and both of them were refusing life-saving blood transfusions.³¹⁴ The judgments are peppered with tributes to the qualities of the young people, their ‘integrity and commitment,’³¹⁵ but the courts show little hesitation in assessing them as incompetent to decide their own futures. In *Re L* the court effectively condoned an approach which effectively prevented the patient from demonstrating competence. The doctor had not felt it appropriate to go into detail with the patient about the manner of death she would experience without treatment. The judge accepted the doctor’s approach³¹⁶ - and then based his assessment of L’s incompetence at least in part on the fact that she did not know all the information necessary to be able to make a competent decision!

It is not simply coincidental that the patients’ choices contradict the judicial assessment of best interests. That contradiction is critical to the assessment of competence, for there are no cases where a young person holding views against the first judicial preference have been credited with competence. (And of course, where the young person’s views accord with what is recommended for her, there is no impetus to question competence in the first place.)

The approach of the courts has now come full circle with the decision of Silber J in *R (Axon) v. Sec. St. for Health*,³¹⁷ where the court robustly asserted that *Gillick* was determinative, and no exceptions should be permitted:

“The speeches of Lord Fraser, Lord Scarman and Lord Bridge do not indicate or suggest that their conclusions depended in any way upon

³¹⁴ For religious reasons – for further discussion of which see below.

³¹⁵ *Re S* p1076

³¹⁶ At p811.

³¹⁷ [2006] EWHC 37, where a mother of 2 girls aged 12 and 15 challenged Department of Health guidance on advice and treatment to be given to young people under 16 about sexual matters, including contraception and abortion. She sought a declaration that unless disclosure would be likely to damage the child’s physical or mental health, there was a duty to consult parents.

the nature of the treatment proposed because the approach in their speeches was and is of general application to *all* forms of medical advice and treatment.”³¹⁸

However, *Axon* was of course about positive access to treatment - the minor’s ability to consent, not refuse. The courts find it easy to condone capacity when it speaks in accordance with objective medical opinion. *Axon* did not concern those cases which offend court instinct, where minors refuse treatment objectively considered good for them. The ‘refusal’ cases were not even referred to in argument or judgment.

Nonetheless, the robust assertion of juvenile autonomy, and the unequivocal application of the *Gillick* approach to *all* treatments, even to matters as difficult for the patient and as controversial to the public as abortion, sets a tone which would be hard to ignore in the context of a young person’s *refusal* of treatment. Respect for the young person’s own views³¹⁹ certainly seemed to be at the heart of the Local Authority’s decision to withdraw their application for court approval of a proposed heart transplant on the consent-refusing 13 year old Hannah Jones, in autumn 2008.

In withdrawing the application, Hannah’s Local Authority denied us the opportunity to test the court’s acceptance of this. It is not difficult to see how a judge could have assessed Hannah as too immature, too ‘overwhelmed’ by her situation, to be credited with capacity to make such a momentous decision. If and when such a case does come to be litigated, it may yet be that there proves to be a difference between the court approach to *hypothetical* cases such as *Gillick* and *Axon*,³²⁰ and its approach to cases of *immediate* effect, such as Hannah’s, in the same way as we have noted a difference between first instance and review

³¹⁸ At para 86

³¹⁹ Hannah’s parents also declined to consent to the proposed treatment, but their decision was said to be based entirely on Hannah’s wishes. As her father told the journalist Elizabeth Grice, “...I just didn’t feel able to influence her. My wife and I agreed that whatever Hannah wanted, we would support her.” (Daily Telegraph. 12th November 2008)

³²⁰ In neither case was there an identified individual with a healthcare issue turning on the decision. The daughters of Mrs. Gillick and Mrs. Axon had not, so far as anyone but their doctors may be aware, taken advantage of the government guidelines in issue. Their mothers were simply testing the theoretical rectitude of the guidelines, in case they (or any girls) ever did!

decisions in respect of adults. Academic caution³²¹ about the re-emergence of *Gillick* pre-eminence may still prove justified.

Conclusions

Like nappies and milk teeth, the incompetence of minors is eventually outgrown. The courts' approach to determinations of capacity borderline by reason of age has been forged in the context of a struggle between parents' and children's rights, but it has implications for the court's own authority too, deriving as it does from parental powers. Courts have long been willing to empower teenage children against their parents, but not so keen to forfeit their own ability to protect the inexperienced from themselves. Where a minor purports to make a treatment decision at odds with paternalism and the judicial preference for life over death, juvenile autonomy is a threat to the courts' sense of themselves as guardians of the objectively vulnerable.

This threat was at the root of the court's reactionary approach to the question of whether consent and refusal are mirror images of the same concept, or legally distinct. The social conservatism of one judge in particular, Lord Donaldson, ensured that a consistent approach has been hard won, ultimately through the impact of legislation. Even so the courts have retained the power to intervene in extremis, and before then will quickly resort to assessments of *incompetence*, to pursue a protectionist agenda and enforce the "best interest" of reaching adulthood. Even if young people may now claim the right to make their own medical mistakes with reasonable hope of success, it is only up to the point where their life is imperilled – but as we have seen in our reflection on the courts' interpretation of borderline competence in adults, this is in any event probably as good as it gets.

³²¹ See for example Anne Morris, "*Gillick, 20 years on: Arrested Development or Growing Pains*", PN 2005, 21(3), 158-175. Published in 2005, she wrote that "it may be too soon to herald the return of *Gillick* to anything like a pre-eminent position (as compared to *Re R* and *Re W*)."

D. Religious beliefs

Medicine is an earthly practice. Its objectives and achievements are focused in this world, with no reference to any other. The same cannot be said of many of its subjects.³²² Belief in a greater power beyond earthly constraints is a common factor in all major religions, and for many adherents the importance of the afterlife exceeds that of the here-and-now. The potential for a clash of priorities is enormous.

Adults: Since an autonomous adult can make the decision to accept or reject proposed treatment for *any* reason at all, it follows that a decision based on religious belief cannot be automatically invalid. Religious faith is by definition irrational, but it is not generally considered to be inconsistent with capacity to make decisions. The faith-based treatment decisions of a competent adult will normally be respected by doctors without challenge, and the patient will be allowed to suffer the consequences,³²³ not because they are grounded in religious doctrine, but because *despite that* autonomy is preserved.

However sometimes the ideological clash is too stark, and the matter is referred to court. As we have already seen in *Re T (Adult: Refusal of Treatment)*,³²⁴ the court adopts a cautious approach - the unspoken assumption is that religious doctrine *threatens* autonomy.³²⁵ If a patient's decision is counter to her objective welfare interests, her adherence to the religious doctrine which demands it will have to be clear and complete for the court to allow it to be determinative. Persuasion based on someone else's religious belief, particularly where that person has influence over the patient, will be said to have overborne independent capacity.

³²² Although there can be no certainty in such things, and no measure of the depth of conviction, popular estimates (see for example Wikipedia) are that around 80% of the population professes a religious faith.

³²³ As was seen recently in a Shrewsbury hospital, when Emma Gough, aged 22, died hours after giving birth to twins because, as a Jehovah's Witness, she refused a blood transfusion: Paul Vallely, *The Independent*, 6th November 2007.

³²⁴ [1992] 3 WLR 782

³²⁵ Per Lord Donaldson at p113-114 "Persuasion based upon religious belief can also be much more compelling and should alert the doctors to the possibility – no more – that the patient's capacity or will has been overborne."

Children: The legal considerations are different, as we have seen, where the patient is a minor. It is one thing for a religiously convinced, autonomous adult to reject a treatment plan which would preserve her own life; but quite another for that same person to make the same decision for someone else. Adults may martyr themselves, but they cannot sacrifice their children on the altar of their belief.³²⁶ As Thorpe J asked in *Re S (A Minor)(Medical Treatment)*³²⁷ “Are the religious convictions of the parents to deny their child a 50% chance of survival? Are those convictions to deny him the 50% chance and condemn him to inevitable and early death?” Courts too are earthly creations. Thorpe J did *not* ask “For a 50% chance of survival in this world, is it worth breaching one’s inner convictions?” “Best interests” are measured in the here-and-now, with no place for conscience or speculative immortality. Inevitably then, in every case³²⁸ where parents have refused consent to life-saving treatment for young children on the basis of religious conviction, their wishes have been overridden.

It should be less inevitable, but the same can also be said of cases involving older children, of borderline capacity, who have expressed their own refusal in unison with the parental view. Religious motivation is more likely to undermine, than support, the sense of developing competence³²⁹ - as Ward J put it in *Re E*³³⁰ one may admire but is also “baffled by” religious conviction which faces death in preference to relatively straightforward medical treatment. The device adopted by the courts to protect the young is to manipulate the threshold of competence.

³²⁶ In *Re E (A Minor)(Wardship: Medical Treatment)* [1993] 1 FLR 386 at p394 Ward J quoted Justice Holmes in the American case of *Prince v. Massachusetts (1944)* 321 *Us Reports* 158: “Parents may be free to become martyrs themselves, but it does not follow that they are free in identical circumstances to make martyrs of their children before they have reached the age of full and legal discretion when they can make choices for themselves.”

³²⁷ [1993] 1 FLR 376 at p380

³²⁸ There have been three reported: *Re S (A Minor)(Medical Treatment)* [1993] 1 FLR 376, where the child was four and a half; *Re O (A Minor)(Medical Treatment)* [1993] 2 FLR 149, where the child was a premature baby; and *Re R (A Minor)(Blood Transfusion)* [1993] 2 FLR 757, where the child was 10 months old.

³²⁹ Lord Donaldson in *Re W* [1993] *Fam* 64 at p80 said that “I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less ‘Gillick competent’. It may however contribute to the difficulties minors of borderline capacity have in establishing such competence, at least in the serious case which become litigated. There are no reported cases of judicial findings of competence, when the minor’s decision has been motivated by religious faith.

³³⁰ [1993] 1 FLR 386 at 394

Even where capacity is not an issue, as in *Re P (A Minor)*,³³¹ the court consideration of ‘best interests’ cedes no ground to religious doctrine. P was 16 years and 10 months old, and it would have been farcical to suggest that his grasp of the situation was any less than it would be in 14 months time, when he became legally adult. The religious motivation behind his refusal of life-saving treatment was simply treated as one of those exceptional cases where the court can override a competent minor. Johnson J made little attempt to manipulate the court’s conception of ‘best interest’ around religious scruple.³³² It is implicit in his judgment that the court simply did not share that particular conviction.

Jehovah’s Witnesses: All of these cases concerned the Jehovah’s Witness objection to use of blood and blood products, when such treatment held excellent prospects for saving a life on earth which would otherwise be needlessly lost, a consequence which clearly weighed heavily with the judges. Nowhere in any of the judgments is there any consideration of *why* the Jehovah’s Witnesses reject the use of blood and blood products, or of what they believe the consequences of treatment against their belief would be. That the court approaches assessment of ‘best interests’ on a purely secular basis is made clear, but at the expense of forfeiting even any impression of respecting personal and family wishes. A basic requirement of respecting other people’s views is first to listen to them, even if you then disagree with them. The Jehovah’s Witness family, whose responsibility to care for the child will continue after her earthly life has been saved, is apparently not even extended that degree of influence.

Yet Jehovah’s Witnesses are not an isolated or extreme sect. There are 130 000 of them in the UK, and almost 7 million worldwide. Consideration of the substance of their belief would make judicial decisions seem *less* hostile to

³³¹ [2003] EWHC 2327, where the minor was 16 years and 10 months old, and it would have been farcical to suggest that his grasp of the situation was any less than it would be in 14 months time, when he became legally adult.

³³² And, as Jane Fortin points out (‘Accommodating Children’s Rights in a Post Human Rights Act Era’ (2006) *Modern Law Review* 299 at 315), no attempt to reconcile his order with P’s rights under Articles 3,5,8 or 14 of the European Convention. She suggests that Johnson J’s decision may be permissible as proportionate to the risks involved in not receiving medically orthodox and life-saving treatment.

individual conscience, and therefore more consistent with the legal emphasis on adult autonomy. If disregarding parents' wishes is as uncomfortable as judges say it is in other contexts, paradoxically, it would also make a secular decision easier to make.

Jehovah's Witnesses are literal believers of the bible. On the basis of four texts,³³³ they believe that blood, as the life-force, belongs to God and is not for human use. These texts refer to eating blood, but blood transfusion is covered by extension because it involves the use of blood as a nutrient, or food, and is therefore comparable. The prohibition on blood consumption is not, however absolute. Jehovah's Witnesses are not, for example, required to be vegetarians. As long as the animal has been bled properly to drain *most* of the blood, it is permissible to eat what remains in the flesh.

When a Jehovah's Witness abstains from blood, he is in effect expressing faith that only the shed blood of Jesus Christ can truly redeem him.³³⁴ Conscientious violation of this doctrine is a serious offence, for which a member is subject to organised shunning (known amongst Jehovah's Witnesses as being "disfellowshipped"³³⁵) with no reason to hope that a pardon from God could be expected.

However Jehovah's Witnesses also believe that when a person dies, their existence stops completely.³³⁶ Since existence is over, nothing can be done to them or for them, so they do not believe in a hell, or eternal damnation.³³⁷ So,

³³³ Genesis 9:4, Leviticus 17: 12-14, Acts 15: 29 and Acts 21:25

³³⁴ See Awake! August 2006 p11

³³⁵ See The Watchtower January 15th 1961 p6 and July 15th 1982 p20; and The Watchtower media release of June 14th 2000, by which the church council changed their policy, so that they would no longer expel members who had willingly had blood transfusions – but only because by so doing they had already excommunicated themselves, so that church action was unnecessary! Disfellowshipping is effectively expulsion from the Jehovah's Witness way of life. Other Jehovah's Witnesses, even close family members, can never again speak to the disfellowshipped. It is a very draconian punishment for those who have either chosen the Jehovah's Witness way of life, or grew up knowing no other.

³³⁶ From Ecclesiastes 9:5, 10.

³³⁷ Each person can be remembered by God and eventually resurrected, when their previous actions will be judged. (From John 5: 28-29: "all those in memorial tombs will hear [Jesus'] voice and come out, those who did good things to a resurrection of life, those who practised vile

when considering the spiritual consequences of a court order for blood transfusion, the key word here is “conscientious”. Wherever the decision to give a transfusion is not made by a Witness but, for example, by a court,³³⁸ the conscience is not violated and there is no offence.³³⁹

It may smack of sophistry, but it is consistent with the wider approach to blood, where absolutes are not required. It is what lies behind Ward J being able to find as a fact that “although [E] will protest, at the end of the day he will respect the decision of this court”³⁴⁰; and it explains why 15 year old S told doctors that “if the court ordered her to have transfusions she would comply;”³⁴¹ and why the parents of L found no difficulty in explaining that they and all the congregation would “support her whatever the order of the court may be.”³⁴² Thorpe J was accurate, apparently without understanding why,³⁴³ when he said of 4 year old S’s family that they would recognise that “consent was taken from them and, as a judicial act, absolves their conscience of responsibility.”³⁴⁴

Paradoxically this belief in non-existence after death means that the clash between courts and Jehovah’s Witnesses is not as cataclysmic as may be the

things to a resurrection of judgment.”) Suffering at the hands of others, against ones own will, is not ‘practising’ anything.

³³⁸ See Mandi Fry, “Jehovah’s Witnesses and Blood Transfusion”, *Christian Medical Fellowship* October 1993 pp2 – 13. This invites the question of how a judge who was herself a Witness would decide such a case? At present there are, and have been, no Jehovah’s Witness judges in the UK.

³³⁹ As the 15 year old patient told Johnson J in *Re S (A Minor)(Consent to Medical Treatment)* 1994 2 FLR 1065 at p 1072: “if [treatment with blood products] was forced upon her it would be like rape and it would be those who had done it would be the sinners.”

³⁴⁰ [1993] 1 FLR 386 at p 394. A submission had been made, on the basis of a Canadian case, that E would physically struggle against the machinery of transfusion. E had said that he was prepared to die for his faith, but he had not given any reason to believe that he would fight against enforcement of a court order which left his conscience in tact.

³⁴¹ [1994] 2 FLR 1065 at p1067

³⁴² [1998] 2 FLR 810 at p 813

³⁴³ It is not clear from his judgment how informed he is about the Jehovah’s Witness belief. Did he know of the exception where transfusion was imposed, or was he simply relying on the positive view he had formed of the parents and their approach to parenting the child? The judgment tends to suggest the latter, because he precedes his conclusion by asking himself what difficulties S would go through being brought up by parents who believed his life was prolonged by an ungodly act. However, the judge in question was Matthew Thorpe, who is generally extremely sensitive to the wider effect of his judgments (as we noted when considering *LB v. Croydon*), and his words follow very closely the phraseology of the exception. It is possible that he was bending over backwards to ensure that no responsibility – not even for acquiescing in someone else taking responsibility – could be laid on the parental consciences.

³⁴⁴ [1993] 1 FLR 376, at p 380

clash with other faiths, where breach of faith may lead to eternal damnation. If judges aim to respect conscience and save lives, the approach routinely adopted with Jehovah's Witnesses is therefore a double tragedy. Where the patient is a minor, the dismissal of parental views need not be so cursory; and when the patient is an autonomous adult, there is no mechanism³⁴⁵ for stepping in to save her from her own conscience.

Whose Values?: Religious principle does not only *reject* secular treatment; sometimes it can demand treatment too. Assuming secular responsibility for denial of treatment raises different issues, because it is not the principle of sanctity of life which is challenged, but its limitations. When orthodox Jews wanted court reassurance that their 16 month old baby could have artificial ventilation reinstated if she deteriorated without it, the courts declined to sanction their approach.³⁴⁶ The doctors considered that C was in a "no chance" situation, and recommencement of ventilation represented further suffering. The parents believed that it was not within their religious tenets to contemplate the possibility of indirectly shortening life, even if that was not the purpose of the doctors' care plan. The court backed professional ethics over personal belief.

The same approach was evident in the case of *An NHS Trust v. X*,³⁴⁷ which concerned the withdrawal of treatment from an elderly man with strong Muslim beliefs. On appeal Lord Justice Waller answered the criticism that the judge had failed to take into account the religious beliefs (of the whole family) in the following terms:

³⁴⁵ Which is why, in the absence of any considerations of capacity, Sir Stephen Brown's decision in *Re S (Adult: Surgical Treatment)* [1993] 1 FLR 26 must simply be wrong. A pregnant woman was refusing consent to a Caesarean on religious grounds. The Health Authority sought a declaration that the operation would be lawful in the vital interests of the patient and the unborn child. The application came to the notice of court officials at 1.30pm, was heard from 2pm and decided at 2.18pm. The President made the declaration sought, with no discussion or hint of capacity considerations, and in the stated belief of no English authority in point. The decision demonstrates a powerful urge to preserve life (and potential life) at any cost, an utter disregard for religious belief, and a woeful ignorance of the law.

³⁴⁶ Sir Stephen Brown, in *Re C (Medical Treatment)* [1998] 1 FLR 384.

³⁴⁷ [2005] EWCA Civ 1145

“The fact that the judge put these at the end of his judgment does not in my view show that he did not have them properly in mind. It should be remembered in particular that the treating doctors had themselves had very much in mind the religious concerns of the family....[The judge] was clearly right to consider what was certainly the key question first, as to whether there was in his view any chance of recovery of quality of life so as to make the discomfort to which [the patient] was being put justified. Once he had formed that conclusion – that it was not justified – it was obviously going to be difficult for the religious views and the views of the family to overcome the obvious point that, since any decision to put [him] through further suffering would produce no benefit to [the patient], it would be difficult to see how it could be in [his] best interests.”

As Holm and Edgar³⁴⁸ point out there are different value systems at play, and for a ‘best option’ to be chosen, one of them has to be dominant. Waller LJ hid it behind “the rhetorical device of presumptive definition”³⁴⁹ when he alluded to a ‘key question’, but in effect he is simply asserting the dominance of the court’s, secular, value system.

Against that background, the legal status of male circumcision must be seen as an aberration. There is a considerable body of medical opinion³⁵⁰ which regards both male and female circumcision as invasive procedures involving unnecessary mutilation of the genitals, yet only female circumcision is criminal. The circumcision of little boys is a matter of religious insistence for Muslims and Jews, and its legality was never challenged until less than a decade ago:

³⁴⁸ ‘Best Interest: A Philosophical Critique’ [2008] Health Care Analysis 197 at p202

³⁴⁹ Holm & Edgar at p 202. In her response to their paper, Sheelagh McGuinness refutes this interpretation, claiming instead that the court was simply ‘protecting the legal rule that patients cannot demand whatever treatment they choose.’: ‘Best Interests and Pragmatism’ [2008] Health Care Analysis 208 at p210.

³⁵⁰ The BMA took steps in this direction in March 2003 and June 2006, in its guidance notes (‘The Law and Ethics of Male Circumcision – Guidance for Doctors’), which state that “Doctors must consider whether their decisions impact on a person’s human rights and, if so, whether the interference can be justified....The BMA does not believe that parental preference alone constitutes sufficient grounds for performing a surgical procedure on a child unable to express his own view. Parental preference must be weighed in terms of a child’s interests...parents must explain and justify requests for circumcision, in terms of the child’s interests.”

Re J (Specific Issue Orders: Child's religious upbringing and circumcision).³⁵¹ J was 5 years old, and living with his mother, a non-practising Christian, in an essentially secular fashion. His father was Muslim, but not particularly observant. In the course of a protracted contact dispute, the father applied for permission to have J circumcised, against the mother's wishes.

Notwithstanding the prevailing view that circumcision for religious reasons confers no medical benefit³⁵² (indeed, it causes pain and discomfort and is prima facie contrary to medical interests), Wall J accepted that it is lawful for parents jointly exercising parental responsibility to impose the surgery on their child. This conclusion is surprising³⁵³ in its deference of medical interests to religious beliefs and cultural identity, and the legal argument employed in justification was not compelling. Wall J accepted weak and unconvincing 'authorities' suggestive of legality, simply because it had always been assumed to be so.³⁵⁴

Perhaps Wall J was simply concentrating his firepower, because on the facts of the case, there was no parental agreement. Wherever there is a dispute between

³⁵¹ [2000] 1 FLR 571. The ratio of the case was followed in *Re S (Specific Issue Order: Religion: Circumcision)* [2005] 1 FLR 236, where circumcision was again found not to be in the child's best interests.

³⁵² Although this may be about to change – see Alex Renton, *The Guardian*, 5th July 2009, 'Failure to Circumcise Men "May Have Cost Millions of AIDS Deaths"'. Renton suggests that the WHO and UNAids may be changing their view about 25 year old evidence which suggests that male circumcision plays a significant role in preventing transmission of the human immunodeficiency virus.

³⁵³ Surprising, that is, in the present consideration of medical decision-making. In a more general context of cultural pluralism Michael Freeman had predicted in 1995 that "in a clash between the value of physical integrity and the value of cultural identity", on the question of male circumcision the latter would prevail. See 'The Morality of Cultural Pluralism' [1995] *International Journal of Children's Rights* (3) 1 at p16.

³⁵⁴ The reasons he gave were actually threefold. He relied firstly on an obiter comment in *R v. Brown* [1994] 1 AC 212 that "ritual circumcision, tattooing, ear-piercing and violent sports including boxing are lawful activities; secondly on a statement in the Law Commission consultation paper 139, "Consent in the criminal law" stated at paragraph 9.2 that "male circumcision is lawful under English common law..."; and thirdly on the BMA's acceptance of male circumcision is accepted by the BMA, albeit that its guidance acknowledged the "male circumcision has never been the subject of a case in English law, but this assumption of lawfulness has never been challenged." For a more compelling argument suggesting that circumcision should be *unlawful* in the absence of statutory provision, see For a discussion of the lawfulness or otherwise of male circumcision, see Howard Gilbert, 'Time to Reconsider the Lawfulness of Ritual Male Circumcision' [2007] *European Human Rights Law Review* 1.

the parents, he (supported by the Court of Appeal³⁵⁵) stipulated that the matter should be referred to court, to be decided by application of section 1 of the Children Act. Judicial assessment of the child's best interests then becomes possible. Once it had the opportunity, the court focussed on religious upbringing, over religious inheritance. Hence, although within religious law, J was undoubtedly Muslim, his daily experience was not. The sympathy of the court lay with secular considerations,³⁵⁶ and circumcision was found to be against his best interests.

More recently, however, there has been one case where the court championed the religious over the secular:

*Ahsan v. University Hospitals Leicester NHS Trust*³⁵⁷ : Negligent surgery left a 43 year old Muslim patient in a persistent vegetative state, and a claim for damages was brought on her behalf. The relevant issue was whether the award for cost of care should be calculated according to residence in a care home (where she presently placed) or at her family home (as the family wished, but more expensive).

The defendants argued that, since she was wholly unaware of her surroundings, the court should look only to physical requirements, and disregard wider issues. However the lead clinician gave evidence that care at home could be said to be in her best interests, not in the sense of simply replicating a treatment regime, but "using the concept of best interests applied to the family as a whole."³⁵⁸ Although the judge declined to give any weight to the spiritual benefit of prayer,³⁵⁹ he was keen to extend due regard and respect for the patient's religious beliefs:

³⁵⁵ Per Thorpe LJ at p576 and Butler-Sloss LJ at p577.

³⁵⁶ Per Wall J at p "It is a strong thing to impose a medically unnecessary surgical intervention on a residential parent who is opposed to it."

³⁵⁷ [2006] EWHC 2624

³⁵⁸ Quoted by Hegarty QC sitting as a High Court Judge, as paragraphs 28 -33.

³⁵⁹ At para 45 "...these are ultimately matters of belief...the spiritual realm is one into which the forensic process cannot venture. It proceeds on the basis of what can be established by evidence and not on the basis of what is believed, no matter how firmly and fervently."

“I do not think for one moment that a reasonable member of the public would consider that the religious beliefs of an individual and her family should simply be disregarded in deciding how she should be cared for in the unhappy event of supervening mental incapacity. On the contrary I would have thought that most reasonable people would expect, in the event of some catastrophe of that kind, that they would be cared for, as far as practicable, in such a way as to ensure that they were treated with due regard for their personal dignity and with proper respect for their religious beliefs.”³⁶⁰

Even though “no tangible benefits, whether physical or emotional”³⁶¹ were likely to flow from recognition of the religious views of the patient (as far as they could properly be attributed to her) or her family, they were the basis on which the court preferred the home care option – and thereby imposed a greater burden of damages on the defendants.

It may be tempting to see this as an instance of the court being prepared to admit a wider test of best interests where the consequences of court decision are merely financial (in the same way that we have seen courts diverge on assessments of borderline capacity according to whether they consider a case in the throes of emergency or with the luxury of hindsight). However, there is a more credible interpretation. The common factor in all of the other cases considered above is that religion was at odds with medicine, and on every occasion the court favoured secular science. In *Ahsan*, the religious imperative dovetailed with the clinical assessment of best interests. Even the defendant’s expert witness acknowledged that, although he disregarded the faith-based wishes of the family in his capacity as an expert, he would take them into account as a clinician.³⁶² The court is, once again, giving preference to the medical view. The more sympathetic approach to both families and religious values is only a happy consequence of the medics taking such an approach themselves.

³⁶⁰ Para 51

³⁶¹ Para 56

³⁶² Quoted at para 53.

The question then becomes, why were the medics able to afford respect to religious values in *Ahsan*, when they had not in any other case? In *Ahsan*, unlike the other cases, the religious demands posed no threat to, may even have enhanced, the medical imperative to make better. When a patient is in a vegetative state, there is nothing medicine can do to improve their physical condition; so there is nothing to lose in trying to promote any other aspects of personhood remaining. When that vegetative state was itself brought about by negligent medicine, it ill behoves the culprits to deny whatever comfort is perceived by the victims. At the point where science can offer no more, medicine will allow faith a place.

That medical professionals should accord such precedence to science is probably inevitable – medicine in the 21st century is a scientific discipline. That the law should accord such precedence to medicine is not inevitable - autonomous adults are not protected from their own religious scruple. *Ahsan* demonstrates that, in cases where treatment disputes arise from religious conviction, the best interests test is primarily a protectionist device.

Conclusions: Religious belief is not the antithesis of autonomy, but courts adopt a cautious approach. Wherever an objectively sensible (and in particular, a life-saving) treatment plan is rejected on the basis of religious scruple, the courts use whatever device is available to them to circumvent the patient's views. When courts determine 'best interests', there is no place in the balancing exercise for religious views if they conflict with scientific ones: only when medical science has run out of things to offer, and in an act of enforced penitence, will courts sanction religious considerations over secular.

E. Immunisation and paternity testing

Much can be achieved with the prick of a needle: a body may be vaccinated against disease, or subject to analysis for genetic inheritance.³⁶³ The experience of the procedure, from the point of view of the patient who is pricked, is very much the same, but the purpose of the procedure, and the court approach to disputes about it, is different. Cases of immunisation and paternity testing both involve children as recipients of a medical intervention, but they demonstrate different uses of the ‘best interests’ test to resolve disputes.

Immunisation

Immunisation of children is not compulsory. The view of the medical establishment is overwhelmingly that immunisation is in the interests of children,³⁶⁴ but if parents jointly take a different view, the law respects their decision.³⁶⁵ This goes further than the everyday reality of parents and doctors reaching rough accord in hospital corridors, because the parental view is actually contrary to medical opinion. There are no instances of doctors challenging a joint parental decision and the court imposing the establishment view on united parents.³⁶⁶ Parents, acting jointly, genuinely have decision-making authority on this issue.

There may be any number of reasons why immunisation has such a special status. It is of course a preventative measure, rather than curative; and it looks to securing herd immunity as much as individual protection. Any vaccination

³⁶³ Or disease carrier status, as in *Re C (A Child)(HIV Testing)* [2000] 2 WLR 270. This type of investigation however rarely comes before the court. There are too few judgments to allow any generalised conclusion of judicial approach.

³⁶⁴ So much so that, in June 2009, Sir Sandy McCara, a former chairman of the BMA, submitted for debate at a BMA conference the motion that children should not be allowed to attend primary schools without a certificate of vaccinations.

³⁶⁵ “Where parents are in agreement that their child should not be vaccinated, the law and doctors respect their view. It is not compulsory and no local authority, doctor, school or other agency would in ordinary circumstances apply to the court for a contrary decision.” Per Sumner J in *Re C (A Child)(Immunisation: Parental Rights)* [2003] EWHC 1376 at para 314

³⁶⁶ Although for arguments in favour of exactly such imposition see Angus Dawson, ‘The Determination of Best Interests in Relation to Childhood Vaccinations’ [2005] Bioethics 72.

carries theoretical risks, however small and generally outweighed by the risk of contacting the disease, so that once herd immunity is achieved, any individual's best interest could rationally be said to lie in *not* accepting those risks. Acceptance of a joint parental decision recognises all these factors – and explains why immunisation has not troubled the courts until relatively recently.

The true sentiment of the court is revealed however in those cases where the parents do not agree, and the issue falls to judicial determination under the best interests test. In the case of *Re C (A Child)(Immunisation: Parental Rights)*,³⁶⁷ where all the standard childhood vaccinations were in issue, although careful to deny that the decision should be seen as a general approval of immunisation,³⁶⁸ Sumner J found the medical evidence in favour of immunisation “clear and persuasive,”³⁶⁹ and then determined that there were no non-medical factors sufficient to outweigh the medical indication of best interests. The Court of Appeal eagerly upheld both his conclusion and his approach.³⁷⁰

On the surface, Sumner J's approach seemed to take an inclusive attitude towards families, albeit strictly from the point of view of the child. With reference to *Re T (A Minor)(Wardship: Medical Treatment)*, he specifically took into consideration the impact which a decision against them would have on the mothers and their care of the children,³⁷¹ reminiscent of an ethic of care. However, on the facts, he dismissed the impact on the child's best interests as negligible – a view which might have emboldened him to consider the matter from that perspective in the first place! The full extent of his consideration of the

³⁶⁷ [2003] EWHC 1376 at first instance and [2003] EWCA Civ 1148 on appeal.

³⁶⁸ At paragraph 358. Whilst the view of the medical establishment remains as it is, the facts which may lead to a different decision are not easy to envisage. Presumably only specific evidence of adverse reaction to immunization would suffice, in which circumstances no one would be likely to bring an application.

³⁶⁹ At paragraph 343

³⁷⁰ Per Thorpe LJ at para 24: as long as the judge “consider(s) all relevant factors...the order in which he takes them is surely for him provided that he keeps each in its proper proportion and ultimately conducts a comprehensive survey.” Sedley J at para 34 referred to the judge's complete discretion: “All the law requires is a logical and practical approach.”

³⁷¹ At paragraph 343. The way was opened for this approach by Wilson J in *Re C(A Child)(HIV Testing)* [2000] 2 WLR 270 at paragraph 58: “A different, yet allied, situation may arise where to override the parents' wishes is to risk causing them such emotional distress as will disable them from caring properly for the child or, at any rate, as will indirectly affect the child's own emotional stability to a significant extent.” However, although he saw the possibility, Wilson J did not espouse it.

family unit was a willingness to contemplate taking steps to protect one mother by prohibiting further litigation³⁷² whilst she adjusted to his decision.

More fundamentally, the Court of Appeal's endorsement of Sumner J's approach, and its downplaying of *Re T*, reveals the assessment of best interests to be strongly medically orientated. In fact the logical conclusion of allowing the determination to proceed by assessment of expert medical opinion first is that, at least where the preferred expert opinion is *against* treatment, that will be determinative³⁷³ - no other factors will ever get to be considered. So the family view will be decisive only as long as it is united. Where there is disagreement, a court assessment of 'best interests' strongly favours medical orthodoxy.

Paternity Testing

Blood testing for paternity is an investigative tool, not a therapy,³⁷⁴ and the court can only make provision for it in relation to wider civil proceedings where the issue of parentage falls to be determined, not as a free-standing application. Its significance is in the results, not in the procedure. However, when the relevant law first developed, the testing process generally required professional medical intervention. A blood test was physically invasive, and as such the principle of autonomy³⁷⁵ loomed large. It was enshrined in statute that no competent person

³⁷² Paragraph 352. In the event, the mother rejected this attempt to protect her interests by herself appealing the decision!

³⁷³ See Case Comment, [2003] Medical Law Review 377.

³⁷⁴ Per Wall J in *Re O & J (Paternity: Blood Tests)* [2000] 1 FLR 418: "A blood test taken for the purpose of determining paternity cannot be said to be either curative or prophylactic, nor is it designed to facilitate diagnosis of any medical condition...Even given the broad definition of treatment contained, for example, in the decision of the Court of Appeal in *B v. Croydon Health Authority* [1995] Fam 133, [1995] 1 FLR 470 at 138 and 473 respectively, I am unable to accept that 'treatment' includes steps taken to avoid the potential psychological damage of children growing up without certain knowledge of their paternity."

³⁷⁵ "A person of full age and capacity cannot be ordered to undergo a blood test against his will.... The real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion; and often it is the first step that counts." per Lord Reid in *S v. S; W v. Official Solicitor* [1970] 3 All ER 107 at p111.

could be forced to undergo such a procedure against their will,³⁷⁶ and testing of a child required the consent of the person with care and control of him.³⁷⁷

As medical science has progressed, better information can be gleaned from even naturally discarded body products, such as hair, so the ethical concerns of the procedure have diminished, or at least moved away from the issue of liberty to issues of privacy. Nowadays testing kits are readily available on the internet,³⁷⁸ so practical reality has reduced the impact of the procedure³⁷⁹ and allowed the court to consider best interests primarily in terms of the impact of results.

The leading case of *S v. S; W v. Official Solicitor*³⁸⁰ predates the Family Reform Act 1969, but was decided in expectation of its coming into force:

S : H and W were married with 3 children. When the fourth child D was born, H denied paternity. He subsequently issued divorce proceedings on the grounds of W's adultery with M. Within those proceedings the question arose of whether D was a child of the marriage, and blood tests were ordered. H and W consent to testing for themselves and D, but M refused.

W : H and W were married with 2 children. W left H and gave birth to P five months later. Two years later, at H's request, W sent H a photograph of the three children. H at once asserted that P was not

³⁷⁶ s21(1) of the Family Law Reform Act 1969 provided that "...a blood sample which is required to be taken from any person for the purpose of giving effect to a direction under section 20 of this Act shall not be taken from that person except with his consent."

³⁷⁷ S21(3) of the Family Law Reform Act 1969: A blood sample may be taken from a person under the age of 16 years ...if the person who has care and control of him consents. (The consent of a minor over the age of 16 was as effective as if he was of full age, by virtue of s21(2))

³⁷⁸ For comment on this see Northover & Dennison, "Genetic Testing and the Impact on the Family", Fam Law 32 (752).

³⁷⁹ The Family law Reform Act 1969 s20 provided for the taking of blood samples only. The Family Law Reform Act 1987 s23 had made provision of testing "bodily samples", but that section was not brought into force because the Home Office perceived "no discernible demand" for tests on anything but blood: Home Office Circular 91/1989. After much delay, the substantive law has now been updated to reflect the availability of less invasive testing procedures. As from 1st April 2001, pursuant to the Blood Tests (Evidence of Paternity)(Amendment) Regulations 2001 (SI 2001/773), it is possible for samples of bodily tissue or fluid other than blood to be taken to determine paternity.

³⁸⁰ [1970] 3 ALL ER 107

his child. W admitted adultery and H issued divorce proceedings, raising the issue of paternity. H and W were willing to consent to testing, but the judge refused to make the order.

Although both mothers were agreeable³⁸¹ to testing the child, they could not arrange for testing without first notifying the Official Solicitor.³⁸² The Official Solicitor objected to testing, on the basis that it had not been shown to be for the benefit of the child.³⁸³ The House of Lords came to consider his arguments, knowing that legitimacy proceedings were on foot and would have to be determined. The question of blood tests effectively decided the evidence which could be heard. The husbands argued that it would be contrary to justice to deprive them of the best evidence (which testing offered), unless it could be shown that tests were *contrary* to the interests of the children.

The nature of the jurisdiction: The Law Lords were unanimous in the view that blood testing did not fall within the “custodial” jurisdiction of the courts, which would require the child’s interests to be paramount.

Lord Reid distinguished the custody cases on the basis that they involved ‘no competing question of general public interest’, whereas in paternity disputes “justice requires that available evidence should not be suppressed...[even though] it may be against the interests of the child to produce it.”³⁸⁴ He doubted that the ordering of blood tests was an exercise of the *parens patriae* jurisdiction,³⁸⁵ but asserted

³⁸¹ Per Lord Morris at pp 119 and 122

³⁸² As noted by Lord Morris at p 119, pursuant to a Practice Direction issued by Sir Jocelyn Simon P, on 21st October 1968.

³⁸³ The implication behind the Official Solicitor’s argument was that a child’s best interests lay in maintaining the status of legitimacy. Lord Reid did not consider this well founded. If the circumstantial evidence pointed towards the husband not being the father, then testing might actually improve the chances of preserving the status. In any event public policy had moved on, and did not require any special protection of legitimacy status. A finding of legitimacy which was not based on the best evidence possible, was unlikely to be convincing so as to mitigate the remaining (chiefly social) disadvantages of conception outside marriage. Per Lord Reid at p111, and generally echoed by Lord Morris at p120. The counter argument was that a child’s interests lie in knowing the truth: per Lord Reid at p111, Lord Morris at 121, Lord Hodson at 123.

³⁸⁴ p112

³⁸⁵ Instead, he said at p 112, “by appointing guardians ad litem and by a *Practice Direction* of the Probate Divorce and Admiralty Division of 21st October 1968, the court prevents parents who

that even if the court was limited to what a reasonable parent would do, a reasonable parent would consider public interest, and not refuse tests unless it would be clearly against the interests of the child.

Lord McDermott identified two categories of court duty to minors. A general “protective” duty (to ensure that a minor did not suffer because of his incapacity) arose whenever a court exercised its powers in litigation where a child was engaged or involved. Its aim was “to ensure that he gets his rights rather than to place him above the law and make his rights superior to those of others.”³⁸⁶ “Custodial” jurisdiction³⁸⁷ was a second category, which could not include blood testing, in the interests of best evidence;³⁸⁸ because giving pre-eminence to the interests of the child would place intolerable strain on the interests of justice,³⁸⁹ and because ascertaining the child’s interests in this context is invariably impossible.³⁹⁰

Lord Morris took a more general approach, balancing the need for best evidence and the need to protect the interests of the minor

retain care and control of their children from exercising their right to have blood tests. Then, when an order for tests is sought the true position appears to be that the court is being asked to lift this ban. I do not see why any special jurisdiction is necessary either to impose the ban or lift it.”

³⁸⁶ p115, and therefore it “would not ordinarily afford ground for refusing a blood test merely because it might, in revealing the truth, prove the infant’s illegitimacy in duly constituted paternity proceedings.”

³⁸⁷ As then encapsulated in the Guardianship of Infants Act 1925 s1: “Where in any proceedings before a court...the custody or upbringing of an infant...is in question, the court, in deciding that question, shall regard the welfare of the infant as the first and paramount consideration...”

³⁸⁸ “It would be a backward step to start to whittle down the effect of s1, but it would just as bad to have to apply it’s final criterion on a finding of fact which was not reached on the best available evidence, and even worse if that had to happen because the court, having sped a paternity issue, considered that it should not be fully explored.” At p117-118

³⁸⁹ “If ...the inherent jurisdiction of the High Court to provide in its discretion for a fair and satisfactory trial – were to give place to the suppression for the benefit of the infant of a means of finding the truth, the conflict between the interests of justice and the advantage of the infant would become too acute to tolerable...” at p 118

³⁹⁰ “..to ascertain whether a full investigation of a necessary paternity issue will be in the best interests of the infant, must by its very nature be so difficult and conjectural as to become an impossible task more often than not.” at p118

according to the circumstances of the case³⁹¹ (but giving precedence to the former on the facts of both these cases).

Lord Hodson saw it as a conflict of interests, in which the court was exercising a duty of arbitrament,³⁹² where all parties' interests were relevant and none took priority.

There was frustrated comment on the impossibility of knowing where the best interests of the child lay,³⁹³ and guarded suggestion that knowing the truth about their paternity is itself in the best interests of children,³⁹⁴ but the outcome of the case did not turn on either of these factors. Effectively the House of Lords recognised that the testing procedure *could* be ordered unless it was *against* the best interests of the person on whom it was to be performed, where justice and the interests of others demanded it – an emphasis remarkably different to all our previous considerations of best interest in the context of medical treatment.³⁹⁵

Lord Reid declined to comment on the operation of the Family Law Reform Act 1969 except to say that lower courts should apply the principles settled by higher courts on the question of when blood tests should be ordered.³⁹⁶ The implication

³⁹¹ “..best evidence should, if possible, be completely available; but [the court] will also steadfastly have in mind that the interests and welfare of infants are always to be zealously protected and safeguarded....A court will have to decide whether, having regard to the facts and circumstances of the particular case, an infant's interests are such that their protection necessitates the withholding from the court of evidence which may be very material.” at p120.

³⁹² “..the court is not truly exercising the custodial jurisdiction in which the interests of the child are paramount but the duty of arbitrament between parties in which their interests are relevant and must be considered as well as the interests of the infant whose body it is sought to examine.”

At p 124

³⁹³ Per Lord Reid at p110 “In most cases it is virtually impossible to determine at the time when the order is sought whether taking the tests would or would not be in the child's interest...”; per Lord McDermott at p118 “to ascertain whether a full investigation of a necessary paternity issue will be in the best interests of the infant, must by its very nature be so very difficult and conjectural as to be an impossible task more often than not.”; Lord

³⁹⁴ Per Lord Reid at p111 “it is said that... it is generally better for the child that the truth should out than that the child should go through life with a lurking doubt...”; per Lord Hodson at p123 “there must be few cases where the interests of children can be shown to be best served by the suppression of truth” and at p124 “ it must surely be in the best interests of the child in most cases that...the child should be told the truth as soon as possible.”

³⁹⁵ Medical treatment disputes fall fairly clearly into the ‘custodial’ jurisdiction, in respect of children by either by virtue of wardship or by statute, and in respect of adults because the inherent jurisdiction was modelled on *parens patriae*.

³⁹⁶ P113 “The Act gives no guidance as to the circumstances in which blood tests should be ordered, and I think that must mean that superior courts are to settle principles insofar as it is

is clearly that the House of Lords expected their decision to be followed long after the Act came into force. When the Act did come into force, that guidance came to be tested in a different context – the import of parental consent. The priority afforded to the interests of the child became the focal point of a power struggle between parents and the court.

The impact of statute: Section 21(3) of the Family Reform Act provided that a blood sample could be taken from a minor “if the person who has care and control of him consents.” Where consent is forthcoming, the court is generally happy to go along with the carer’s decision³⁹⁷ - but not always. Where the carer’s request for testing is motivated by a desire to frustrate court proceedings, the court has refused it:

*O v. L*³⁹⁸ : V was born in December 1990 and raised as the child of H and W, who were married. They separated 3 years later, and W then indicated that her new cohabitant was V’s father, not H. H applied for contact, and within those proceedings W applied for blood tests. The Court of Appeal upheld findings that W’s motivation was to prevent contact; that contact was likely to be in V’s interests irrespective of the outcome of blood tests; and that precise definition of the biological relationship was not necessary to foster contact.

In terms of *S v. S*, this case could be seen as an instance of testing being against the child’s interests,³⁹⁹ except that Wall LJ observed that resolution of the paternity dispute “would undoubtedly be in [V’s] interests” sooner or later.⁴⁰⁰

necessary to disturb existing law in order to comply with the Act, and thereafter the lower courts are to apply those principles to cases which come before them.”

³⁹⁷ See for example, *Re T (A Minor)(Blood Tests)* [1992] 2 FCR 663: mother initially refused consent, and the first instance judge refused the direction. Having changed her mind whilst appeal was pending, the Court of Appeal made the direction with a very short judgment. Bingham LJ at p664 gave the only hint of reasoning, namely that “it probably is desirable in the interests of the child and her long-term relationship with these parties.”

³⁹⁸ [1995] 2 FLR 930

³⁹⁹ In the immediate circumstances, the possibility of a finding that H was not V’s father may have an unhelpful effect on contact proceedings, whereas the assumption of legitimacy was supportive.

⁴⁰⁰ At p 937. The modern view is that even unpalatable truth is preferable to uncertainty.

The case is more accurately interpreted as an instance of the public interest in not endorsing W's attempt to manipulate proceedings outweighing V's presently uncertain personal interests – again a very different emphasis to the one we have identified in disputes of medical treatment, except that in both instances the court holds the upper hand.

Similar concerns may arise where a parent with care *refuses* consent, but in this scenario, the balance of power is critically affected by statutory provision. Until recent statutory amendment, the court did not in fact *order* a blood test to take place but merely *directed* that it *may* take place.⁴⁰¹ The ultimate decision of whether testing will actually take place or not lay with the parent with care and control, who had the power of consent pursuant to s21(3) Family Law Reform Act 1969. This balance of power is in marked contrast to that vigorously defended by the court in matters of medical decision making (where the court listens to parental wishes, but ultimately makes its own decision). Fortified by a modern shift of attitude very much in favour of openness about biological origins, the court has fought hard against its apparent lack of authority, and ultimately overcome it.

The unusual precedence of parental authority over court authority was apparently accepted by the House of Lords in *S v. S; W v. Official Solicitor*,⁴⁰² but on a clearly obiter and unconsidered basis. In the same vein but (in terms of precedence) more powerfully, the Court of Appeal specifically upheld Callman J's decision on that point in *Re F (A Minor)(Blood Tests: Parental Rights)*.⁴⁰³ As Balcombe J put it

⁴⁰¹ As was made clear by Ward LJ in *Re H (A Minor)(Blood Tests: Parental Rights)* [1996] 2 WLR 506 at p99, quoting the Law Commission paper upon which the Act was based. "The distinction...has not always been fully understood and the misunderstanding has created confusion."

⁴⁰² "No case has yet occurred in which a court has ordered a blood test to be carried out against the will of the parent who has the care and control of the child, and I am not certain that it would be proper to do that or that it will be possible to do that after Part III of the 1969 Act comes into operation." Per Lord Reid at p112. It would later be pointed by Ward LJ in *Re H (A Minor)(Blood Tests: Parental Rights)* [1996] 2 WLR 506, that Lord Reid was giving judgment before the passing of the Act, and therefore failed to distinguish between the power to order or to direct.

⁴⁰³ [1993] 3 WLR 369.

“the court will not order a blood test to be carried out against the will of the parent who has since birth had sole parental responsibility for the child.”⁴⁰⁴

The court’s dismissal of the applicant’s counter-arguments has been strongly criticised by Jane Fortin as demonstrating judicial preference for marriage, and short-term stability over long term truth,⁴⁰⁵ and it may be that the Court of Appeal found it easy to accept the parental priority because of the particular facts of the case.⁴⁰⁶ However the marriage had already broken down, and the mother was into a third relationship by the time Wall J decided *Re CB (A Minor)(Blood Tests)*,⁴⁰⁷ recognising a parental veto even whilst taking a dim view of the parent,⁴⁰⁸ so the preference to which Fortin objects cannot have been a motivating factor.

In any event it was an opposing line of cases, decided *against* the claims of short-term stability and marriage,⁴⁰⁹ which eventually carried the day. Sitting as a Deputy High Court Judge, Mr. Michael Horowitz QC in *Re G (A Minor)(Blood Test)*⁴¹⁰ looked to the sequence of events involved in testing, and concluded that

⁴⁰⁴ At p321

⁴⁰⁵ See “Re F: The Gooseberry Bush Approach” [1993] 1 FLR 598. Because of these factors, at p301 she concluded that “the answer in Re F, implicit though unstated, was that the court at both levels concluded that E’s welfare would actually be endangered by B’s application and this outweighed the interests of justice to B.”

⁴⁰⁶ Where the application was brought by “a stranger to the marriage, ... to satisfy his own desire to know the truth about the consequences of a relationship with the mother that has terminated well before the birth” per Callman J, quoted at p319. The Court of Appeal placed clear priority on maintaining the stability of the family unit within which the child was being brought up (see p 320 – 321). Practitioners came to advise on the basis of this approach, and the effect was seen in *K v.M (Paternity: Contact)* [1996] 3 FCR 517: having withdrawn his application for blood tests on advice that the court would not accede to it, the third party’s contact application was then simply dismissed on paper.

⁴⁰⁷ [1994] 2 FLR 762

⁴⁰⁸ At p763: “Neither Mr. F nor Mrs. B emerge with any credit in this case and both were...thoroughly unsatisfactory witnesses. Each, but particularly Mrs. B., radiated a degree of hostility towards each other that was almost tangible....her dislike of him permeated almost every answer she gave.”

⁴⁰⁹ In *Re G* the marriage had already broken down, and whatever stability had been achieved was with the third party to the marriage. The granted the husband’s application for testing, even though he was noted to be a crack addict and contact was likely to be inappropriate. In *Re H* the marriage was subsisting, but the court granted the third party’s application for testing.

⁴¹⁰ [1994] 1 FLR 495.

the Act envisaged the giving of a direction even though it may subsequently remain unimplemented.⁴¹¹

Wall J in *Re CB (A Minor)(Blood Tests)*⁴¹² distinguished *Re G* on the basis that the mother may have been willing to change her mind,⁴¹³ but in truth the force of the refusal was not determinative for Mr. Horowitz QC. He cited the possibility of change of heart only to illustrate the theoretical value of a direction even without powers of coercive implementation.

The Court of Appeal agreed with Mr. Horowitz QC. In *Re H (A Minor)(Blood Tests :Parental Rights)*⁴¹⁴ the effect of Wall J's approach was abundantly obvious. It is a litigation reality that parties express their case to fit the law.⁴¹⁵ Where expressions of non-compliance will lead the court not to make the order litigants oppose, they are encouraged to say they will not comply, and exactly that process was at play in *Re H*.⁴¹⁶ On the basis of the distinction between the power to order and to direct, the Court of Appeal held that even dogmatic refusal of consent was *not* determinative of an application for paternity testing:

“the legislature would not have made express provision that a refusal to comply with direction has a specified consequence if a refusal to submit to tests would have compelled the court not to make a direction at all.”⁴¹⁷

⁴¹¹ “s20 empowers the court to give a direction and then, by s21(1), refers to a blood sample ‘which is required to be taken’, and then goes on to provide that where there is such a requirement the blood shall not be taken from that person except with his consent. The scheme of the Act plainly envisages...that a direction may be given with which the adult may not comply and her non-compliance would not be unlawful or visited by the coercive powers of the court” pp499-500

⁴¹² [1994] 2 FLR 762 at 773

⁴¹³ By Wall J in *Re CB* at p 773, where it was found as a fact that the mother would not consent in any circumstances.

⁴¹⁴ [1997] Fam 89 at 101

⁴¹⁵ As previously discussed in the context of carer's burden in the sterilisation cases.

⁴¹⁶ Ward LJ quotes from the first instance decision of Coningsby J at p96: “I think they know the importance of categorically stating that they will not in any circumstances give consent to blood tests.”

⁴¹⁷ An interesting parallel may be drawn with birth registration. Mothers have much greater ability to subvert the truth of biological origins in the details they supply for birth registration, where the court has no powers at all.

If Fortin's interpretation of judicial preference (for marriage and stability) were the only one at play, then *Re H* would have been decided differently. Instead, Ward LJ was quite dismissive of the idea that the married relationship needed to be protected from the risk of destabilisation which tests represent.⁴¹⁸ Similarly, although the marriage in *Re G* had already ended, upholding the parental veto would have been expected as at least preserving the presumption of legitimacy.⁴¹⁹

These decisions are better explained by a judicial urge to protect court jurisdiction from manipulation by a parent. In *Re G* the mother's refusal was grounded in her desire to protect from challenge the cohabitant's belief in his paternity,⁴²⁰ rather than any direct consideration of the child. And in *Re H* the first instance judge explicitly saw the mother's refusal as tactical, owing much to the decision in *Re CB*.

Those cases which Fortin sees as supportive of marriage are consistent with this view of judicial motivation too. In *Re F*, it was the applicant trying to use court procedure to his advantage in a factual scenario where his claims had minimal chance of success. And in *Re CB*, Wall J's concern was that the statutory provision of a right of veto for the parent with care leads to unsatisfactory litigation.⁴²¹ If an order was never going to be implemented, he considered the

⁴¹⁸ He said at p 108 "If the cracks in the H marriage are so wide that they will be rent asunder by the truth then the piece of paper which dismisses the application hardly seems adhesive to bind them together."

⁴¹⁹ Whereas in fact Mr. Horowitz specifically saw advantages in distancing the child from the husband, at p501: "he has been and may still be a 'crack' addict and has a criminal record, and there may be strong issues as to his suitability or unsuitability ..."

⁴²⁰ "...the mother and CB say they wish to make their life together. They say..that if the blood test came out positive in favour of the husband, this would be news that was, to say the least, unwelcome. I am far from satisfied that the interests of the child and justice require the mother and CB to maintain a belief which they wish was true but which was not in fact true..." at p502

⁴²¹ "The jurisdiction given by the statute is...unusual and unsatisfactory from the point of view of conventional jurisprudence. The normal judicial process is that the judge makes an order if (a) he or she thinks it is the right thing to do; (b) on the basis that it will be implemented; and (c) on the basis that it will be enforced...s221 makes it quite clear that the litigant is given an absolute veto in relation to implementation of the court's order....I have to say that it is unusual for a judge to be asked to resolve an issue which is said to be justiciable, and in respect of which he has a discretion...at the same time for him to be told that whatever he decides will not be implemented. This will particularly be the case if the judge perceives that refusal to consent is either irrational or otherwise ill-founded....I recognise the situation which results from my decision is unsatisfactory, since it permits a litigant whose conduct may be open to severe

order ought not to be made. He had focused on procedure, whereas Mr Horowitz and the Court of Appeal focused on substance, but the urge to avoid manipulation of the court was the same.

Having established its authority to make directions, the court then set about securing implementation of its will. Frustration with the idea of parental veto came to a head with Hale J's judicial gymnastics in *Re R (A Minor)(Blood Test: Constraint)*.⁴²² The case report gives absolutely no information about the background facts. There is no description of the adults involved, and apparently no consideration of what interests they may have had in the outcome of paternity testing. All that can be gleaned is that the child's mother refused consent to blood testing in the face of an unexplained judicial determination that testing would be in the child's best interests. Hale J made the startling order that the child be delivered into the care and control of the Official Solicitor, who was then to provide both the consent and the opportunity for samples to be taken.

Removing a 22 month old child from her primary carer is a draconian measure by any scale. The Official Solicitor had serious reservations about his part in it.⁴²³ In fact, it was never implemented, because the mother changed her mind and gave consent – which probably says more about the frightening and coercive effect of judicial orders than it does about the mother's views on testing. Furthermore, when the opportunity to repeat the tactic arose again in *Re O & J*,⁴²⁴ Wall J dismissed it (and every other possibility that was argued) as an impermissible device to circumvent the plain provisions of statute. However, he went further than his earlier expressions of dissatisfaction⁴²⁵ and made a stark call for legislative reform. He even made a veiled threat that, if the legislature

criticism, and who may not be acting in the best interests of the child, effectively to dictate what should or should not happen." At pp768 – 769, 770 & 774.

⁴²² [1998] 1 FCR 41

⁴²³ According to Peter Jackson, Counsel acting as amicus curiae in the subsequent case of *Re O & J (Paternity: Blood Tests)* [2000] 1 FLR 418, at p431.

⁴²⁴ [2000] 1 FLR 418

⁴²⁵ In *Re CB*. See above.

did not act, the courts would force their hand by declaring the relevant parts of the statute incompatible with the anticipated Human Rights Act.⁴²⁶

The combined effect of *Re R* and *Re O & J* was impressive: a legislative amendment was duly arranged.⁴²⁷ The new s21(3) provides that in the case of a child aged under 16 either the person with care and control may consent or, alternatively, the court may do so, if it considers that it will be *in the child's best interests* for the sample to be taken. The result is twofold: firstly, that a parent can no longer thwart the will of the court, and secondly that the principle on which the court acts is identical to that used in immunisation (and all medical treatment) cases.

Jurisdiction after statutory amendment: In theory, the statutory amendment did nothing to alter the basic nature of paternity testing disputes. In Lord McDermott's phraseology,⁴²⁸ paternity testing is still a matter for the court's protective jurisdiction only, not its custodial jurisdiction. When the amendment was first tested, within six weeks of its taking effect, in the case of *Re T (A Child)(DNA Tests: Paternity)*⁴²⁹ Bodey J explicitly recognised this:

“..the welfare of T is not paramount... Instead, one has to apply the test of his best interests, weighing those best interests against the competing interests of the adults who would be affected one way or another, according to whether the application were granted or refused.”⁴³⁰

This formulation of the law surely offers the best of both worlds: the interests of a vulnerable minor safeguarded, but assessed in the context of interdependence,

⁴²⁶ “If Parliament does not implement reform, the law in this area will continue not to serve the best interests of children. In these circumstances I anticipate that reform may need to be achieved when the Human Rights Act 1998 comes into force, by the point being taken that Part III of the 1969 Act is not human rights compliant.” At p 434.

⁴²⁷ By s 82 of The Child Support, Pensions and Social Security Act 2000 (“CSPSSA 2000”), which took effect from 1st April 2001.

⁴²⁸ In *S v. S* [1970] 3 All ER 107, and footnotes 385 and 386 above.

⁴²⁹ [2001] All ER (D) 82. The case also determined the Human Rights Act argument, as Wall J had foreseen.

⁴³⁰ At page 1194

where everyone affected is freely able to express their interests. It articulates precisely the model advocated in the ethical considerations of chapter 2. Its interpretation in practice offers insights into how the recognition of family interests in medical treatment disputes may work in reality.

The facts of *Re T* were somewhat unusual:

The child's mother and her husband were unable to conceive a child together, and agreed that the mother would have sex with a third party. Over a three month period she had sex with A, a family friend, frequently but no pregnancy resulted and the mother terminated the arrangement. Ten years later the mother renewed her efforts, having intercourse with A and three other men. She became pregnant and gave birth to the child, T, who was raised as the husband's.

For a while, A saw T in the capacity of family friend, but the mother terminated the friendship because she considered that A was becoming too demanding. A's adult daughter subsequently let out information doubting T's paternity to others, including the mother's niece and nephew who attended the local school. In a public row, A asserted his paternity with a placard at the husband's place of work and on CB radio, and then claimed parental responsibility and contact orders from the court. The Family Proceedings Court refused blood testing. Six years later, when T was 7 years old, A renewed his application.

Bodey J correctly identified the need to weigh the child's interests against the competing interests of affected adults. He made a clear assessment that knowing the truth of his parentage was in the child's best interests. In contrast, his consideration of the interests of the mother, her husband and A is vague. None of them present a flattering portrait in the facts of the case, and the interests they claim are largely ignoble. The settled relationship between the mother and her husband was actually cited as a reason in favour of testing, rather than seen as being threatened by it. The court overrode maternal opposition to testing on the

basis that her own “understandably strong feelings” precluded her from “seeing sufficiently clearly and objectively the best long-term interests of T.”⁴³¹

Clearly, the recognition of third party interests as a legitimate part of the equation did not in any way hamper the court’s instinct, or its ability, to use the ‘best interests’ test as a means to impose its own views. The mother (and her husband) were able to argue their interests openly, rather than distorting them as indirect aspects of the child’s interests, and the court was still able to find them wanting. The admission of third party interests to the balancing exercise was demonstrably not a threat to the court’s ability to advance the interests of the vulnerable party.

The Court of Appeal confirmed such a conclusion in the case of *Re H & A*,⁴³² where again the facts were less than flattering of the adults involved:

The mother had an extra-marital sexual relationship with Mr. B over a prolonged period, with her husband in total ignorance. When twins were conceived and born, she initially allowed both men to believe they were the father, and her husband became the primary carer of the children. Mr. B began legal proceedings, including an application for blood testing. When the husband accidentally became aware of the proceedings, he gave evidence that he could not carry on in the family unit if the twins proved to be another man’s children.

The judge at first instance refused testing, but the Court of Appeal overturned his decision. All of the adults were able to argue their own perception of interests, but none of them dominated considerations of the higher court, which simply found that HHJ Morgan had given too little weight to the importance of certainty, and too much to the risk of driving the husband away.⁴³³ The Court of

⁴³¹ At p 1196

⁴³² [2002] EWCA Civ 383

⁴³³ Paragraphs 21, & 28; and paragraph 24. Per Thorpe LJ at para 27 “of the greatest significance are my misgivings over the judge’s strongly expressed assessment that to order the test would be to drive Mr. R from the family...the reality was that Mr R was on an incomplete journey of discovery of truth. Major adjustments still had to be made. There was much with

Appeal gave the preservation of marriage very little weight on the balancing seesaw - which represents an interesting counterpoint to Jane Fortin's argument about judicial preference. Arguably, the court was giving greater weight to the competing interest of justice for the applicant - but the judgment is not expressed in those terms. In reality, the interest which weighed most heavily in this case was that of truth, not from the perspective of any of the parties involved, but from the perspective of the court.⁴³⁴

Re T and *Re H & A* together demonstrate that, once 'best interests' are imported anywhere into the judicial balancing exercise, it is more or less certain that the court's view of optimal outcome will be secured. Whatever the theoretical analysis of jurisdiction, the effect of a judicial assessment of 'best interests' is to facilitate the objectively preferred end result. Given the preferences identified earlier in the chapter as inherent in the judicial concept of 'best interests', the jurisdiction becomes custodial in all but name.

Conclusions: Immunisations are a medical intervention of preventative care, within the custodial jurisdiction of the court. Paternity testing is non-therapeutic and therefore falls within the protective jurisdiction. However experience of the procedure, at least when the approach of the courts was first worked out, was virtually the same and offers the starting point of a convergence which has increased in law even as it has decreased in physical experience.

Motivated by the need to protect its own and the public interest, the courts demanded and ultimately achieved statutory amendments which elevated 'best interest' considerations into the basis for exercise of its powers in paternity testing cases. In effect the court now exercises its power in a quasi-custodial

which he had yet to come to terms, including a more realistic acknowledgment of the chances that Mr. B was the father of the twins. Mr and Mrs R had much to reconcile if their marriage was to endure. The complex processes which would have to continue post judgment might equally well be assisted by certainty, which may bring relief or which may alternatively at least excise doubt and suspicion. Unpalatable truth may be easier to live with than uncertainty."

⁴³⁴ Per Thorpe LJ at para 30: "Were the judge's order to stand in the present case the consequence would be a long and acrimonious trial of the paternity issue when, in the absence of the only decisive evidence, each side would resort to evidence of marginal or doubtful worth in the determination to prevail. Such a development would be wasteful of both legal costs and judicial time."

fashion. Subsequent cases have demonstrated that giving a legitimate place in considerations to the interests of third parties represents no hindrance to the court's ability to secure its own view of optimal outcome.

These same cases also demonstrate, however, an unimpressive selection of third party interests. Does it follow that, even if fully recognised, family interests in medical treatment disputes would be as easily outweighed as they appear to be in paternity testing disputes?

There is reason to hope not: the context is all. Paternity issues lend themselves to defensive parenting. The proceedings arise from adult behaviour which is rarely flattering and leads to self-justification and self-protection. The scope for conflict between the interests of parent and child is great. On the other hand, therapeutic medical interventions usually have a very different background. There is no equivalent impetus for defensive parenting. The dispute is about how best to go forward, not how to re-write the past, and judicial "irritants" are less central to the case. Paternity testing cases show us that courts *can* weigh competing interests, but they do not necessarily imply that family interests will *always* be easy to dismiss.

F. Conclusions

The determination of someone else's interests is a heavy responsibility. The suggestion that judicial assessments of 'best interests' are shaped not just by the facts of individual cases, but also by the social and cultural values of the decision-maker is neither surprising nor particularly controversial:⁴³⁵ like any other process, the outcome reflects what goes in. What goes into court assessments of 'best interests' in cases of medical treatment dispute becomes apparent when the cases are categorised according to their principal issue.

⁴³⁵ For an example of the same contention in a related context, see Professor Fennell in 'Best Interests and Treatment for Mental Disorder' (2008) *Health Care Analysis* 16 255 at 266.

The inherent jurisdiction was forged in the context of sterilisation, whose special features invited a protectionist, reactive and individualistic approach to ‘best interests’. It developed in the context of a moral debate about life over death, where social implications compelled a tight hold on powers of determination, even to the extent of manipulating assessments of competence and overriding tenets of faith. The net result was a concept of ‘best interests’ which limited consideration of families to the purely instrumental. The impact of treatment decisions on the families in whom the patient’s life is embedded has no place in the determination unless and until that impact becomes such as to affect the patient’s own wellbeing. The effect of this is to distort the representation of cases, and encourage the very dissemblance which engenders suspicion of families and drives the urge to maintain exclusive powers of determination.

Yet such a limited role for families is not a necessary corollary of maintaining a protective jurisdiction. In the struggles to work out the ambit of their newly invented jurisdiction, the courts settled on a *wide* understanding of interests and the mechanism of a *balancing exercise* to measure competing claims. Both of these factors lend themselves to affording the family a greater, more open role. When it is accepted that ‘best interests’ encompass social, emotional and psychological considerations, it is hard to see how a patient should be seen in any way other than as fully social, enmeshed in a network of relations implying both benefit and burden; and the experience of paternity testing cases demonstrates that even competing interests of family members can be admitted into a balancing exercise without abandoning an appropriate regard for the patient.

Having concluded that recognition of families in the resolution of medical treatment disputes is both important to individuals and society, and possible within the mechanisms adopted in the development of the inherent jurisdiction, the failure to afford such recognition can be asserted as a major criticism of the common law. The next consideration should be whether the legislature has done any better.

Chapter 5

Mind the Gap: The Bournemouth Litigation and Statutory Reform

This chapter considers the wider influences and pressures which challenged the common law approach to medical treatment disputes, and led ultimately to new legislation.

The problems of decision-making in the informal care of adults who lack capacity had already engaged political attention when the Bournemouth litigation subjected the inherent jurisdiction to the scrutiny of European Convention standards, and found it wanting. The total exclusion of a patient's family by his medics was seen as a powerful indicator of detention, in respect of which the common law doctrine of necessity provided inadequate safeguards.

The Government proposed statutory reform of the decision-making process in respect of persons lacking capacity, which led Parliament to pass the Mental Capacity Act 2005 and amendments to the Mental Health Act 1983. Judicial developments of the inherent jurisdiction pending enactment represent the last gasps of an exhausted approach, stretched beyond coherence.

In 1997, the extent of the inherent jurisdiction in respect of adults came to be tested as never before in the case of *R v. Bournemouth Community and Mental Health NHS Trust ex p L*¹ :

L was an autistic man, severely disabled and in need of 24 hour care. He had no capacity either to refuse or consent to treatment. He had lived in a hospital for over 30 years, then been discharged to live with paid carers, Mr. and Mrs. Enderby. Three years into their care,

¹ Court of Appeal judgment at [1998] 1 All ER 634; House of Lords judgment at [1998] 3 All ER 289.

whilst at a day centre on 22nd July 1997, he became agitated. Mr & Mrs Enderby could not be contacted, so a doctor was called, which led to L being taken to hospital and admitted to the mental health behavioural unit.

A dispute arose when the Enderbys wanted to take L home. The hospital told them that L had been admitted on an informal basis, without time limit. Even though the Trust regarded it as important for L's future that he should return to live with the Enderbys "as soon as this is practical,"² it did not consider that time to have arrived. The Enderbys were not allowed even to visit L.³

Mr. and Mrs. Enderby regarded L as 'one of the family'.⁴ There is no consideration in any of the judgments which followed of either the accuracy or relevance of this. From the facts as stated, it is difficult to draw any firm conclusions about whether the relationship between L and the Enderbys would satisfy the understanding of 'family' adopted for the purposes of current considerations.⁵ The element of payment for their provision of care suggests not, but payment is not necessarily incompatible with family, as the operation of the welfare benefits system acknowledges. In support of their own perception of 'family', is the clear fact that L had lived as a dependent in the Enderbys household for some three years. The relationship was clearly not quasi-marital, but it was quasi-parental, and parenthood is the essence of 'family life'. The lengths to which the Enderbys went in order to secure contact with L suggests a sort of emotional interdependence: clearly L was much more to them than a paying lodger. In the novel of L's life, the Enderbys were certainly major characters, and vice versa.

In any event, whether or not the Enderbys themselves were L's 'family' makes little difference to current considerations because they acted in full concordance

² Per Lord Woolf in the Court of Appeal at p637; per Lord Goff in the House of Lords at p291.

³ Per Lord Woolf in the Court of Appeal at [1998] 1 All ER 634 at 637.

⁴ Per Lord Woolf in the Court of Appeal at p636; per Lord Goff in the House of Lords at p291.

⁵ See chapter 1 above.

with E's biological and legal family. It is implicit in the judgments that L's cousin, who was sufficiently engaged in L's welfare to front the legal proceedings, performed little or no practical caring role. Given the unanimity between the Enderbys and the cousin, even if the practical care and the biological connection were provided by different 'members', L had a 'family', and it was *that family* which together challenged the decisions of the medical team. With the cousin acting as 'next friend', L applied for judicial review of the Trust decision, contending that he was being detained unlawfully, and seeking a writ of habeas corpus.

The Trust's response was that L was not detained, since he had been admitted informally (that is, without recourse to powers under the Mental Health Act 1983), and remained in hospital without restraint. In the alternative, the Trust argued that, if he was detained, then such detention was lawful under the common law doctrine of necessity, since treatment was in his best interests.

The case was uniquely important for two reasons. Firstly, and of particular concern to current considerations, it set the family and the medics in absolute opposition on the question of the patient's immediate needs. The family was exemplary, and agreed by all parties at all times to represent the best long-term provision for L. Nonetheless, medics made decisions which excluded the family totally, and did so without apparently even considering the impact of such exclusion on either the family or the patient himself.⁶ When the family challenged the medics, the court resolution of their dispute would *have* to take a stance on the role of the family in medical decision-making. The issue did not come before the court framed in those terms because the law is not conceived that way. Overtly, the case turned on the question of personal liberty of adults lacking capacity, but its resolution would by implication say as much about family influence as it did about individual liberty.

⁶ Calling to mind the actions of social workers in Cleveland, which lead to the Cleveland Enquiry and ultimately to the Children Act 1989.

The other importance of the *Bournewood* litigation is the impact it had on the development of the law, both statutory and common law pending enactment. By the time the case reached its ultimate conclusion in the European court, the UK government had been forced to recognise, and subsequently repair, the weaknesses of the inherent jurisdiction. It had also had the opportunity of testing out in advance the compliance with European standards of the proposals which became the Mental Capacity Act 2005.

The first judgment in the long litigation trail came on 9th October 1997 when Owen J determined that L was not being detained, and so dismissed his application. That decision, which is not reported in full, seems to have relied on the fact that L had neither resisted the transfer to hospital nor attempted to leave.⁷ His capacity to resist and, later, to leave (either from his long-term mental condition or because he was given drugs to sedate him) appears not to have been questioned. At first instance, the decision was a straight-forward application of the ‘best interests’ test under the inherent jurisdiction: the medical view was endorsed in preference to the arguments of L’s family.

On L’s behalf, the family appealed. The Court of Appeal decision was handed down on 2nd December 1997.⁸ In the same month, the government consultation paper on capacity, *Making Decisions*, was published. (For a chronology of the litigation and legislative processes, see Appendix 3).

The Court of Appeal disagreed with Owen J on the primary question of detention, which it gave it an objective definition:

“... a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be

⁷ Lord Nolan later quoted Owen J: “L has at all times been free to leave because that is a consequence of informal admission, and he will continue to be free to leave until Dr. Manjubhashini or somebody else takes steps to ‘section’ him or otherwise prevent him from leaving.” ([1998] 3 All ER 289 at p301)

⁸ *R. v. Bournewood Community & Mental Health NHS Trust ex p L* [1998] 1 All ER 634.

permitted to leave those premises and have the ability to prevent him from leaving.”⁹

Since the hospital refused to discharge L to his carers,¹⁰ his circumstances amounted to detention – and herein lay the novelty of the *Bournewood* litigation in respect of the inherent jurisdiction. The Court of Appeal went on to ask, in respect of adults, how far the common law doctrine of necessity – the jurisprudential basis for both doctors’ intervention and the judicial assessment of ‘best interests’ – was compatible with statutory powers.¹¹ Over many years, Parliament had made provision for the treatment *in detention* of adults lacking capacity through a series of Mental Health Acts. The Court of Appeal had to determine whether the current provisions, set out in the Mental Health Act 1983, precluded the common law doctrine (and therefore the inherent jurisdiction). In other words, could an assessment of a patient’s ‘best interests,’ by medics or by judges, bypass statutory provision and extend even to depriving them of their liberty?

With the emphatic force of a single judgment, Lord Woolf, Philips and Chadwick LJ determined that this was a step too far.¹² Their decision was not made lightly: it involved examination of statutory provisions during the history of mental health reform, and going against opinions expressed in authoritative textbooks.¹³ There were two main limbs to the Court of Appeal reasoning.

⁹ Per Lord Woolf at p639

¹⁰ The Enderbys “had made it plain that they wanted to take him back into their care. It is clear that the hospital was not prepared to countenance this. If they were not prepared to release L into the custody of his carers they were not prepared to let him leave the hospital at all. He was and is detained there.” Per Lord Woolf at p640. For the Court of Appeal, the exclusion of the family was key to the finding of detention.

¹¹ Insights could have been gained from the decision of Wall J in a case concerning minors, *Re C* [1997] 2 FLR 180, especially pages 197-198. However, as Munby J later acknowledged in *City of Sutherland v PS* [2007] EWHC 623 at para 24, ‘Curiously, and unfortunately, its significance as an indication of how the inherent jurisdiction with respect to incapacitated or vulnerable adults should properly be exercised has... never been appreciated.’

¹² “Our conclusion is that the right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of the common law principle of necessity...” p645

¹³ Per Lord Woolf at p647 : Hoggett *Mental Health Law* (4th Edn, 1996) p9 and Jones *Mental Health Act Manual* (5th edn, 1996) p340.

Firstly, relying on government command papers,¹⁴ section 131¹⁵ of the Mental Health Act (which preserves the right to admit a patient to hospital informally), was said to address the position of a positively *consenting* patient only.¹⁶ L did not resist, but he lacked capacity to consent, and was therefore beyond the scope of the section. Secondly, the common law powers of necessity were considered available only to *individuals* to protect someone who is ill, whether that illness is due to physical or mental causes; where the 1983 Act covers the situation – as it does where admission to and treatment in hospital is concerned - no necessity to act outside the statute can arise. L was therefore detained without lawful authority.¹⁷

The effect of the Court of Appeal's decision was dramatic for L. The Trust immediately admitted him under section 3 of the Mental Health Act. Three days later L made an application to the Mental Health Review Tribunal for discharge. Before that application could even be heard, on 5th December he was released to Mr. and Mrs. Enderby's care and on 12th December he was discharged from hospital. In other words, when statutory safeguards forced the Trust to measure their actions against statutory criteria, what had been done under the purported authority of common law was quickly acknowledged to be inappropriate. Medical power was reined in, and the patient restored to the care of his family.

The effect of the decision was – or was said to be - *also* dramatic for the wider healthcare services. No fewer than three parties - the Secretary of State for

¹⁴ “We think that the position was accurately stated in *Review of the Mental Health Act 1959* (Cmnd 7320):....’1.6 There is nothing in the Act which authorises or implies that an informal patient may be compelled without his consent to enter hospital or to receive treatment...’ We also note the pragmatic advice given in para 1.8: ‘Where the patient does not have the mental capacity to know what is taking place an absence of objection on his part cannot in law be taken as either implying or withholding consent to admission...’” [Woolf 645-6]

¹⁵ S131(1): Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained.

¹⁶ Woolf at p645

¹⁷ Although any euphoria that his legal success may have brought on was quickly dampened by the court's move to discourage any claim for damages: referring to *Murray v. Ministry of Defence* [1988] 2 All ER 521, where it was said that a person unaware of imprisonment and suffering no harm can normally expect only nominal damages, that is all the Court would have been prepared to award. [per Lord Woolf at p648]

Health, the Mental Health Act Commission and the Registered Nursing Homes Association - were granted leave to intervene in the appeal to the House of Lords. In their submissions to the Lords, these intervenors collectively contended that, if the Court of Appeal decision was allowed to stand,

“...large numbers of mental patients who would formerly not have to be compulsorily detained under the 1983 Act will now have to be so detained....There will be an additional 22 000 detained patients resident on any one day as a consequence....plus an additional 48 000 admissions per year under the Act¹⁸... [T]he majority of th[ose affected].. would be patients in need of long term care.... [I]f the judgment is held to apply to patients receiving medical treatment for mental disorder in mental nursing homes not registered to receive detained patients, the above estimates would be very much higher. It is obvious that there would in the result be a substantial impact on the available resources; ... not only for the mental health services and professionals who have to implement the 1983 Act, but also for mental health review tribunals and for the commission itself.”¹⁹

These predictions represented an Armageddon for legal bureaucracy and institutional care, and they had a powerful impact on the reasoning of the House of Lords. Lord Goff sets them out in detail and in a position of prominence, early on in the speech which led the way to overturning the decision of the Court of Appeal, on 25 June 1998. Lord Steyn seems to view them as the only justification for a conclusion which he otherwise finds unpalatable.²⁰

(In fact these dire predictions never materialised. In the years between the European judgment, which effectively supported the Court of Appeal approach, and the coming into force of statutory reforms, there was not a significant

¹⁸ Against a background of the average number of detained patients resident on any one day in England and Wales being approximately 13 000, according to the evidence of the Mental Health Act Commission.

¹⁹ Per Lord Goff at p293

²⁰ “If considerations of financial resources are put to one side, there can be no justification for not giving to compliant incapacitated patients the same quality and degree of protection as is given to patients admitted under the 1983 Act.” (at p303)

increase in the number of applications to detain involuntary patients under section 3. It seems unlikely that the Department of Health would be so very inaccurate in its estimated numbers of people subject to *de facto* detention; or that so many people's living conditions were suddenly modified so that detention was no longer an issue. More probably, as Scott-Moncrieff²¹ has argued, large numbers of people simply continued to be unlawfully detained. The House of Lords, of course, could not have known this, nor could their Lordships have countenanced it anyway.)

On the primary question of detention, Lords Goff, Lloyd and Hope considered that L had not in fact been detained, on the basis that he had not attempted to leave, and his ward was unlocked. This interpretation of the requirements of detention was, however, explicitly tied to the requirements of the tort of false imprisonment,²² upon which L's application for habeas corpus was based. By somewhat pedantic insistence on the elements of an ancient English tort, the majority circumvented rigorous consideration of the concept of 'detention', in order to reach a desired conclusion.

The Lords were not, however, unanimous in their pedantry. Lords Nolan and Steyn disavowed such an approach. Lord Nolan agreed with the Court of Appeal, looking to the actions of the Trust in refusing to release L to the care of the Enderbys, and practical reality:

“...if Mr L...was not detained ...there was no ground in law upon which the hospital and its staff could be called upon to justify their unwillingness to release him.”²³

Lord Steyn was still more forthright:

²¹ In 'Two Steps Forward, One Step Back' (2007) *Journal of Mental Health Law* 107

²² “I should record at once my understanding that the question is whether the tort of false imprisonment has been committed against Mr. L and I do not wish the use of the word 'detention' in this context to distract attention from the true nature of the question.” He then refers to the Court of Appeal's statement of detention, as per Woolf 639 and notes that “...no mention is here made of the requirement that, for the tort of false imprisonment to be committed, there must *in fact* be a complete deprivation of, or restraint upon, the patient's liberty” per Lord Goff at p297.

²³ At p302

“... this case falls on the wrong side of any reasonable line that can be drawn between what is or what is not imprisonment or detention....The argument of no detention stretches credulity to breaking point. The truth is that for entirely bona fide reasons, conceived in the best interests of L, any possible resistance by him was overcome by sedation, by taking him to hospital and by close supervision of him in hospital, and, if L had shown any sign of wanting to leave, he would have been firmly discouraged by staff and, if necessary, physically prevented from doing so. The suggestion that L was free to go is a fairy tale.”²⁴

Strictly speaking, the majority having found no detention, it was not necessary to determine the question of lawful justification, but the issue was addressed as one of importance. At the point where ‘best interests’ are determined, the House of Lords *was* unanimous.

Section 131 of the Mental Health Act 1983 was traced back to an identical provision at s5(1)b of the 1959 Act, which was enacted following the recommendation of the Percy Commission over half a century ago, that compulsory detention should only be used where necessary.²⁵ Consequently, the section was intended to authorise two types of admission – the voluntary patient (who, having the capacity to consent, did consent) *and* the informal patient (who, lacking such capacity, did not object). By extension, the current s131(1) preserved the common law principle of necessity as a means of admitting compliant incapacitated individuals.²⁶ Even Lord Steyn was convinced.²⁷

²⁴ At p305

²⁵ “We therefore recommend that the law and its administration should be altered, in relation to all forms of mental disorder, by abandoning the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it.” At paragraphs 289, 290 and 291, quoted by Lord Goff at p295.

²⁶ For Lord Goff (at p297), “It was plainly the statutory intention that informal patients would be treated as best interests required. Such treatment could be justified on the basis of common law doctrine of necessity and did not require statutory justification.

²⁷ At p307: “On orthodox principles of statutory interpretation the conclusion cannot be avoided that s131(1) permits the admission of compliant incapacitated patients where the requirements of

So the matter of legal jurisdiction was resolved, and in a manner fully reminiscent of *Re F*: the process of statutory reform had clouded the intentions of history, and the doctrine of necessity was the means by which order was restored. Given the dire predictions which so impressed the Lords, once again precisely *whose* necessity was being met must surely be questionable.

With the legal basis for their actions affirmed, the Law Lords were unanimously agreed that the doctors treating L had met the standards required of them²⁸ - his 'best interests' had been served. In reaching that conclusion, the absence of critical consideration of the doctors' decisions is quite remarkable. Nowhere is there any consideration of countervailing considerations, even though it was acknowledged that the Enderbys had managed to cope with L's "tantrums" before,²⁹ and it was the medics' ultimate intention that he should return to live with them. There is no consideration of the potential for *damage* to his interests in removing him, and keeping him apart, from his surrogate family.

Had such arguments been canvassed, it is possible that the facts would have justified a conclusion that the benefits of hospitalisation outweighed them, but their total absence evidences the danger inherent in the common law approach (as developed up to this point): when 'best interests' are evaluated, too much power vested in the medics. Judicial interpretation tends to disregard other points of view, even those who fulfil the difficult role of 'family' with undisputed success. When medical assessment of a patient's 'best interests' can bypass

the principle of necessity are satisfied....I have to accept that the view of the CA on the meaning of s131(1) cannot be upheld."

²⁸ Per Lord Goff at p297 "All steps taken were justified as according to L's best interests." Lords Lloyd and Hope agreed, at p301 and 308 respectively. Lord Nolan put his agreement in explicit terms, and ahead of his dissension on the point of dissension, at p 301: 'I am satisfied that the trust and its medical staff behaved throughout not only in what they judged to be the best interests of Mr. L, but in strict accordance with their common law duty of care and the common law principle of necessity.' Lord Steyn does not descend to detailed consideration of the doctors' decisions and actions, taking it for granted that they would be properly motivated. Having accepted that the common law doctrine was preserved, he simply says (at p307) "The detention and treatment of L was lawful".

²⁹ Per Lord Woolf at p636, 'Mr & Mrs Enderby are capable of coping with incidents when they occur. During the four years L was living with them police were not called and L had not needed to be admitted to hospital.' Whether the Court of Appeal would have been any more willing to examine the substance of the doctors' decisions is a moot point, because, finding that the jurisdiction did not exist, there was no reason to pursue their considerations that far.

statutory provision and extend even to depriving them of their liberty, in its the exercise of the inherent jurisdiction the court can not only disregard the family unit; it can effectively approve its dismantling too.

The House of Lords' preservation of the common law doctrine may have been economically advantageous to government and institutional care providers, but it came at substantial cost to patients such as L. Any compliant incapacitated patient was thereby denied the safeguards provided by legislation³⁰ and left at the whim of discretion. As Lord Steyn put it,

“This is an unfortunate result...It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care to patients and that they invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are (sic) sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients.”³¹

Given that compliant incapacitated patients are diagnostically indistinguishable from compulsorily detained patients, the result was a gaping hole in the protective scope of the law. Ironically, that jurisdiction which was born of an urge to protect incapacitated individuals was now shown to leave them vulnerable, and at least partly because of that unbalanced approach to medical views which we have already identified as detrimental to family interests. It became known as ‘the Bournewood gap’, and to many – including Lord Steyn³² – it was indefensible.

³⁰ Lord Steyn listed them: the limitation on admission to a maximum of 28 days for assessment, or 6 months for treatment, and only on the written recommendation of 2 doctors; the requirement, pursuant to s58, of either consent or a second opinion before certain treatments are given; the right to apply to the Mental Health Review Tribunal; entitlement to after care services; the protection of the Code of Practice; and the supervision of the Mental Health Act Commission.

³¹ At p307-308

³² At p303

L's family were not minded to accept the House of Lords ruling, and they pursued his claim to the European Court. Whilst the litigation was pending, and the government was preparing its defence, there was undoubtedly much high level thinking about relevant issues going on in government circles.³³

- In October 1999 the government published its proposals for a new law on capacity. They included provision for a general authority to make wide-ranging decisions (about care and welfare, as well as medical matters) on behalf of an incapacitated person, if the decider acted reasonably and in the incapacitated person's best interests.
- In June 2002 the government also published a draft Mental Health Bill and a consultation paper. One of the twin objectives³⁴ of the Bill, as described in the consultation paper, was to bring the law more closely into line with modern human rights' law (notably the case law of the European Convention on Human Rights). Specifically, part 5 of the Bill was entitled 'Informal Treatment of Patients Not Capable of Consenting' and provided safeguards for qualifying patients. Government proposals acknowledged the vulnerability of the common law to the criticisms of Lord Steyn and the Court of Appeal, but sought to reinforce the practical advantages of Lord Goff's majority decision.
- On 17th June 2004 the Mental Capacity Bill was introduced in the House of Commons. It provided for a detailed statutory framework to empower and protect vulnerable people not able to make their own decisions and for safeguards not currently available under the common law.

Just 16 weeks later, on 5th October, the European Court gave its decision in *Bournewood*.³⁵

³³ See the Chronology of Legislative and Litigation Progress at Appendix 3.

³⁴ The other was to provide a legal structure for requiring mentally disordered persons to submit to compulsory treatment without necessarily requiring them to be detained in hospital

³⁵ HL v. United Kingdom (2005) 40 EHRR 32

At the European level, L complained that he had been detained in violation of Art 5(1) of the Convention; and that the procedures available for review of the legality of his detention did not satisfy Art 5(4).³⁶ The two provisions are closely related but not overlapping. The former regulates the circumstances in which one's liberty can be taken away, whereas the latter requires a review of its legality thereafter.

On the question of detention, the UK defence³⁷ was set in the context of a purported national preference, long-held, for the 'informality, proportionality and flexibility' of common law over the formality of statutory procedures, and the resource implications. It was argued that compulsory powers imposed a stigma,³⁸ from which a person already suffering from a socially difficult illness should be shielded: just as incapacitated persons requiring medical treatment could be admitted and treated in hospital informally in his or her best interests, so too should incapacitated persons requiring psychiatric treatment. Consensual non-imposed treatment was considered more likely to attract a degree of cooperation from the patient and to be therefore more therapeutically beneficial; and the informal process afforded the required dignity to the patient.

The European court was unpersuaded.³⁹ In particular, it considered itself unfettered by the House of Lords' finding on detention because it had adopted

³⁶ Art 5(1)(e): Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: (a) the lawful detention of persons for the prevention of spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.

Art 5(4): Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

He also claimed that he had been discriminated against as an 'informal patient' under Art 14, but this was later determined to be subsumed within the Art 5 claim – para 145. Finally he claimed just satisfaction under Art 41, but his success in both Art. 5 claims was itself considered to be just satisfaction for any non-pecuniary damage – an affirmation of the Court of Appeal's view.

³⁷ The UK arguments are summarised at para 80 of the judgment.

³⁸ Perceiving mental illness, and the use of coercive powers in respect of it, is certainly a long-held national preference – recall the arguments in *Re R (A Minor)(Wardship: Consent to Treatment)* [1991] 3 WLR 592 and footnotes 278 – 280 of chapter 3.

³⁹ The ECHR reasoning as to the question of detention is set out in paragraphs 90 and 91 of the judgment.

the tortious test, rather than the Convention concept of ‘deprivation of liberty’⁴⁰ in Art 5(1), to which the distinction between actual restraint and restraint which was conditional upon his seeking to leave, was not of central importance.⁴¹ Instead, the key factor was that the health care professionals exercised complete and effective control over L’s care and movements from the moment he presented acute behavioural problems to the date he was compulsorily detained. The court repeated Lord Steyn’s description of suggestion to the contrary as ‘fairy tale’.

On the question of justification, the ECHR accepted that the common law doctrine of necessity did accommodate the minimum conditions for lawful detention,⁴² but did not satisfy the further element of lawfulness – namely, the aim of avoiding arbitrariness:

‘...the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. ... In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission...and, consistently, no limits in term of time, treatment or care attached to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of the disorder warranting detention. The nomination of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection afforded to those committed involuntarily under the 1983 Act and which would be of equal

⁴⁰ For consideration of the European concept and its application to persons of unsound mind, see the cases of *Winterwerp v. The Netherlands* (1979) 2 EHRR 387, *Guzzardi v. Italy* (1980) 3 EHRR 333, *Neilsen v. Denmark* (1988) 11 EHRR 175, *HM v. Switzerland* (2002) 11 EHRR 175.

⁴¹ “The Court recalls that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.” Para 90

⁴² Although it found that, at the relevant time, the doctrine was still developing and each element of it may not have been fully defined: paras 116-118

importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities.... As a result... the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual, solely on the basis of their own clinical assessments completed as and when they saw fit: as Lord Steyn remarked, this left 'effective and unqualified control' in their hands."⁴³

The absence of procedural safeguards failed to protect against arbitrary deprivations of liberty on grounds of necessity, and therefore violated Art 5(1). None of the suggested procedures for redress were sufficient to satisfy Art 5(4)⁴⁴. Interestingly, the government relied, in part, upon the declaratory jurisdiction of the High Court, but it made no serious attempt to present an argument on that basis. It could not cite a case where the court had found a 'serious justiciable issue' in parallel circumstances because there had not been one. There never could have been, because as the House of Lords acknowledged in *Re F*, the lawfulness of the action under consideration whenever the court exercises its declaratory jurisdiction is independent of any declaration. The European Court properly dismissed the notion of the declaratory jurisdiction as a protective safeguard, quite summarily.⁴⁵

So, the government lost. L, his family and the Court of Appeal were vindicated. Allowing medics to exercise complete and effective control of a patient was not acceptable. Where did that leave the government proposals for reform, and the question of resources? By now government proposals included notions which were ultimately enacted as the Deprivation of Liberty Safeguards, amendments to the Mental Capacity Act by the Mental Health Act 2007⁴⁶, and the indications of the European court were favourable. It was recognised that the proposals set

⁴³ Para.s 120 & 121

⁴⁴ At paras 136 - 140: Neither Habeas corpus nor judicial review were wide enough to bear on those conditions which were essential for lawful detention on the ground of unsoundness of mind. The actions for false imprisonment and assault did not involve the submission of expert evidence, or court assessment of that expertise, and no case was cited in which that had happened. The declaratory jurisdiction had never been used in a relevant way.

⁴⁵ Para 141

⁴⁶ Although public consultation on those proposals did not start until after the European decision in *Bournewood*. (See chronology in appendix 3).

out to meet government policy concerns, but at the same time made provision for “detailed procedural regulation of the detention of incapacitated individuals.”⁴⁷ Perhaps the proposed statutory regime could articulate the best of both worlds: the informality, proportionality and flexibility of the approach carved out at common law, *and* the procedural safeguards and certainty of statute.

However, the passing of legislation takes time. Whilst the Mental Capacity Bill and the amendments to the Mental Health Act were progressing through the enactment procedure, the common law marched on. When the question of detention arose again in the context of an incapacitated patient, the courts had to reconcile the inherent jurisdiction with the European Court’s pronouncements – and it fell to Munby J to work out how. He gave judgment in the case of *JE v. DE, Surrey County Council*⁴⁸ on 29 December 2006:

DE was 76, blind and suffering significant short-term memory impairment. He needed extensive assistance with daily living, but was able to express his wishes and feelings with some clarity and force. An interim declaration had been made that he lacked capacity to decide where he should live. His wife, JE, was his usual carer, but she suffered intermittent mental health problems of her own. Following an incident on 4th Sept, she felt she could no longer care for DE, placed him in a chair on the pavement in front of their house, and called the police. Surrey CC put DE in residential care home X on 4th September 2005, and subsequently moved him to a different home, Y, on 14 November 2005. The care notes recorded that from the very first day DE was repeatedly saying that he wanted to go home with JE.

JE brought an action under the inherent jurisdiction claiming that Surrey County Council had breached DE’s rights under Art 5⁴⁹ of the European Convention on

⁴⁷ Para 122

⁴⁸ [2006] EWHC 3459

⁴⁹ See f/n33 above

Human Rights, and both JE and DE's rights under Art 8.⁵⁰ The question for Munby J to determine was whether DE had at any (and if so what) time since 4th September 2005 been, and was he then being, deprived of his liberty by SCC?⁵¹

Although SCC tried to suggest that DE would not have been prevented from leaving had he actually tried to,⁵² Munby J looked to practical reality as it was experienced by DE. The message given to him was precisely to the opposite effect.⁵³ The crucial question was not his freedom within the institutional setting, but his ability to 'remov[e] himself permanently in order to live where and with whom he chooses...'⁵⁴ On that basis DE was and continued to be detained: "A person can be as effectively 'deprived of his liberty' by the misuse or misrepresentation of even non-existent authority as by locked doors and physical barriers."⁵⁵ The judgment of the Court of Appeal in *Bournewood* was vividly replayed, and the House of Lords' pedantry eschewed.⁵⁶

Having demonstrated that the common law approach was capable of interpreting facts in an ECHR-compliant fashion,⁵⁷ Munby J then felt able to reassert the

⁵⁰ Art 8(1) Everyone has the right to respect for his private and family life, his home and his correspondence

(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

⁵¹ Para 11

⁵² Summarising SCC submissions at para 105: iv. The only limitation is that it is the clearly-expressed view of SCC that it would not be in his best interests for DE to return to live with JE; indeed SCC 'will not agree' to DE returning to live with or visit with JE. Likewise it is SCC's view that it is not in DE's best interests to go on unplanned, unaccompanied outings with JE when she is unsettled or unstable, so that she would not be able to keep him safe

⁵³ para 107

⁵⁴ Para 115

⁵⁵ Para 125

⁵⁶ Expressly, at para 14

⁵⁷ Later cases have not always followed the same line. In particular the finding of no detention by McFarlane J in *LLBC v TG* [2007] EWHC 2640 on 14th November 2007, is apparently at odds with the approach of Munby J. It is best explained on the basis that in *TG* the point was never fully argued – the family were representing themselves and their submissions did "not descend to the necessary detail required to determine whether or not Art 5 applies" (para 107). McFarlane J simply said that the submissions of the Local Authority and the Official Solicitor supported his conclusion, and noted that it was important the TG's placement had been authorised by the court, under orders which gave the family the power to apply to vary or discharge, and were continued by consent at a time when they were represented. (para 109) Moreover, by the time judgment came to be given, there was a broad agreement that TG should stay with the family, coupled

inherent jurisdiction at the next opportunity, which came on 9th March 2007, in the case of *City of Sutherland v PS* ⁵⁸ :

PS was a lady of 82, lacking capacity and in poor physical health. When ready for discharge from hospital, her daughter CA told the hospital she was intending to discharge PS to her own (CA's) care, rather than to the T Unit, where she had lived for the previous 6 months. On the Local Authority's ex parte application Bodey J made an order under the inherent jurisdiction providing for PS to be placed in the T unit until a full hearing the following Tuesday. Munby J then made declarations that PS lacked capacity⁵⁹, appointed a receiver, and granted injunctions to prohibit CA from doing anything to prevent PS remaining at the T Unit.

The Local Authority wanted injunctions because it was concerned that if it took steps itself to prevent PS leaving or being removed from the T unit without the protection of an appropriate order of the court it might fall foul of Art 5,⁶⁰ as the care authorities had in *Bournewood*. This raised two questions: firstly, whether the court had jurisdiction to make such an order, and secondly, if it did, when and how it should be exercised.

To Munby J, it was 'quite clear'⁶¹ both that the jurisdiction existed, and that it extended to 'authorising that person's detention ... and the use of reasonable

with serious concerns about their ability to work with authorities. On a practical level, findings of deprivation would not have helped anything.

⁵⁸ [2007] EWHC 623

⁵⁹ On five separate issues – to litigate, to decide where she should reside, to decide who she should have contact with, to decide on issues concerning her care, and to manage her financial affairs (para 4). This function-by-function approach to capacity reflects the influence of the Mental Capacity Act, by now enacted but not yet in force.

⁶⁰ Para 7

⁶¹ Para 16. When dealing with the appointment of a receiver, in respect of which provision is made in Part VII of the Mental Health Act 1983, he was characteristically bold, at para 32: "Nor, so far as I am aware, has the existence of a parallel statutory regime ever been treated as fettering the parens patriae jurisdiction on relation to children save in those cases where the statute in question either ousts the jurisdiction altogether or specifically regulates or fetters the exercise of the jurisdiction. I can see absolutely no reason why the inherent jurisdiction in relation to incapacitated or vulnerable adults should be any different...."

force (if necessary) to detain him and ensure that he remains there.’⁶² He touched only briefly on the history of the jurisdiction (in whose development he had already played a significant part) before concluding that the court could grant “whatever relief in declaratory form is necessary to safeguard and promote the vulnerable adult’s welfare and interests,”⁶³ and his concept of detention was expressly in the sense of Article 5. Herein lay his only acknowledged limitation of the inherent jurisdiction: that “since the court is a public authority for this purpose...any exercise of its inherent jurisdiction must...be compatible with the various requirements of Art 5.”⁶⁴ He set about making it so.⁶⁵

The inherent jurisdiction needed to be ‘mould[ed] and adapt[ed].’⁶⁶ Crucially, to achieve compatibility on the standard of ‘lawfulness’, the inherent jurisdiction needed precision.⁶⁷ Munby J provided it, *deus ex machine*, in a statement of minimum requirements⁶⁸ :

- i. the detention must be authorised by the court on application made by the Local Authority and *before* the detention commences. (*“the requirement for prior court sanction”*).

⁶² As we have seen, the question of whether the use of force came within the jurisdiction had already been determined by Johnson J over a decade previously, in *Norfolk & Norwich Healthcare Trust v. W* [1996] 2 FLR 613.

⁶³ Para 13

⁶⁴ Para 18

⁶⁵ At para 22 he quotes Sedley LJ’s observation in *Re F (Adult: Court’s Jurisdiction)* [2000] 2 FLR 512 at 532 that “One of the advantages of a declaratory remedy... is that the court itself can do much to close the so-called Bournemouth gap in the protection of those without capacity.” In fact, such is Munby J’s skill in shaping the inherent jurisdiction pending full operation of the Mental Capacity Act that Gillian Douglas wonders (in a case commentary to *Re GJ, NJ & BJ* in [2008] Fam Law 997 at 999) whether that Act, which was so long in the making (and, one might add, the related amendments to the Mental Health Act 1983) is now necessary at all.

⁶⁶ Para 22

⁶⁷ To meet the standard of lawfulness, any legal provision must be ‘sufficiently precise to allow the citizen – if need be, with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail.’ (Para 20iia) Specifically in the context of the detention of incapacitated persons, domestic law must give effect to the principle that an individual cannot be deprived of his liberty on the basis of unsoundness of mind unless three minimum conditions are satisfied: he must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.

⁶⁸ At para 23.

ii. Subject to the exigencies of urgency or emergency the evidence must establish unsoundness of mind of a kind or degree warranting compulsory confinement. In other words, there must be evidence establishing at least a *prima facie* case that the individual lacks capacity and that confinement of the nature proposed is appropriate. (“*the evidence requirement*”).

iii. Any order authorising detention must contain provision for an adequate review at reasonable intervals, in particular with a view to ascertaining whether there still persists unsoundness of mind of a kind or degree warranting compulsory confinement. (“*the review requirement*”).

These minimum requirements were subsequently fleshed out in the case of *Re GJ, NJ and BJ (Incapacitated Adults)*,⁶⁹ when detailed timetables and arrangements were set out for review of the court-authorised detention, both at the interim stage and after the final hearing.

Rather than constraining common law powers, the effect of these ‘minimum requirements’ is simply to shift the focus of its exercise. As we established in earlier chapters, the House of Lords made clear when overriding the Court of Appeal in *Re F* that the inherent jurisdiction is *declaratory*, not *permissive*. On a proper legal analysis, the court does not ‘authorise’ anything under the inherent jurisdiction. It merely gives a neutral scrutiny and opinion of ‘best interests’, which is the guiding principle of the doctors’ actions under the doctrine of necessity. Court approval of the medics’ decision was never the legal justification of the doctors’ subsequent actions; even in the most sensitive issues like sterilisation and withdrawal of life-saving treatment, it was only a matter of good practice. Munby J’s requirement for prior court sanction of a patient’s detention is therefore legally incoherent.

⁶⁹ [2008] EWHC 1097. The post-hearing reviews can be compared to references to the Mental Health Review Tribunal in respect of formally detained patients.

If a court is to give its prior sanction, Munby J ordains that the evidence requirement must be met. The threshold is very low. It requires no more than the doctor would need to satisfy his own professional standards anyway, so it is difficult to see how relaying it to a court offers an increased protection. The additional filter of a judicial brain as well as the recommending doctor's is unlikely to make a substantial difference, given the long history of deference to medical opinion⁷⁰. It need hardly be pointed out that the evidence requirement does nothing to remove the established blinkers in respect of families and family interests. And by what standards is the 'appropriateness' of confinement to be judged? Judicial discretion is as unfettered under Munby J's minimum requirements as it was under the original jurisdiction.

The review requirement purports to limit the arbitrary potential of medical authority by imposing an obligation on doctors to justify their decisions on a continuing basis. There has long been power to achieve similar effect in cases of detention under statutory powers, but only to the lower judicial authority of a Tribunal. Such an ongoing role for the court under the inherent jurisdiction is novel⁷¹ and would amount to an extension of authority. No more defensible than the other of Munby J's minimum requirements, it merely amounts to periodic repetition of their follies.

Far from delivering precision, Munby J has offered uncertainty in the pursuit of incoherence. Rather like his decision in *Burke*, Munby J's judgments in *Sunderland* and *Re GJ, NJ & BJ* may have tackled the demands of the moment with a vigour which is at first compelling, but they carry implications for law which are unsustainable. In truth, the coming into force of the Mental Capacity Act and the deprivation of liberty safeguards represent for the now distorted inherent jurisdiction the dignified release which Munby J, of all judges, should welcome.

⁷⁰ See for example *Bolam v. Friern Hospital Management Committee* [1957] WLR 582 and *Maynard v. West Midlands RHA* [1984] 1 WLR 634.

⁷¹ At least for adults, and it brings to mind the debate around the Children Act, when the intention of statutory reform was to *limit* the use of inherent jurisdiction to one-off considerations, curtailing the ongoing role of wardship.

Conclusions: The *Bournewood* litigation fell like a tsunami on the inherent jurisdiction. As a basis for treating incapacitated (but compliant) patients, the doctrine of necessity, the very basis of the jurisdiction, fell foul of European Convention standards because it failed to avoid arbitrariness. The self-invented power of the courts to make declarations of a patient's 'best interests' was, and could be, no protection against such failure, because the lawfulness of an action based on the doctrine of necessity is independent of any court declaration. Subsequent judicial attempts to paper over this central failing are the dying gasps of a jurisdiction, like Mary the weaker of the conjoined twins, fated to die.

By implication, the *Bournewood* litigation also rejected the dominance of the medical approach to treatment decisions. The English judgment closest to the approach of the European court was that of the Court of Appeal, for whom the total exclusion of the family by the medics had been an important indicator of detention. When that decision forced the treating doctors to reconsider L's position, they rapidly accepted that his treatment conditions should change. The *Bournewood* litigation forced courts to recognise that a patient's interests needed safeguards against arbitrariness; it should also tell us that an important part of that is hearing the voices of a patient's family.

Ultimately, the *Bournewood* litigation showed up the inherent jurisdiction for what it always was – a pragmatic response to a practical difficulty, lacking intellectual rigour and ethically vague. Well-intentioned it may have been, but fit for the twenty-first century it was not.

Both independently and driven by the *Bournewood* litigation, in any event statutory reform was on the cards. The Mental Capacity Act was conceived in the demands of common law pragmatism, and nurtured in the decisions of the inherent jurisdiction. Its birth, just as the judicial approach expired at the European hurdle, could not have been more timely. Whether a patient's family fares any better in the decision-making process under the new legislation is considered in the final chapter.

Chapter 6

New Legislation: The Mental Capacity Act

This chapter considers the role of the family in new legislation. It argues that the Mental Capacity Act 2005 fails to acknowledge the unique characteristics of families, referring to them only as a subset of carers. Even though it is primarily patient-focussed, the ‘best interests’ checklist is susceptible to family-friendly considerations; but the general authority operates to exclude the family from a decisive role in significant issues. The overall effect of the legislation will be to leave families largely in the same position as they were in under the inherent jurisdiction, whose ethos shaped the statute both before and after enactment.

The *Bournewood* litigation was a significant pressure on government to reform the law relating to incapacitated adults, but it did not arise in a vacuum. Like all pivotal moments of the common law, the litigation reflected the concerns of the time as much as it drove them.

Government agencies had been considering some of the issues which *Bournewood* raised even before the first instance decision, with the Law Commission’s report, ‘Mental Incapacity,’¹ published in February 1995. Medical advances and community care policies had made mental incapacity, and the need for decision-making which goes with it, visible in the community in a way which had never been experienced before and politically, recognition of the issue had dawned.² The sheer numbers of people whose lives are affected by the mental

¹ In which it was noted to be “widely recognised that, in this area, the law as it now stands is unsystematic and full of glaring gaps. It does not rest on clear or modern foundations or principle. It has failed to keep up with social and demographic changes. It has also failed to keep up with developments in our understanding of the rights and needs of those with mental disability.” (para 1.1)

² *Who Decides?* para 2.2 : ‘The number of people over 85 will increase by 30% in this decade. Advances in health care and in living standards mean that many people will now live longer. The incidence of incapacity increases as people get older. Dementia of all types affects over 5% of all those over the age of 65. In those over 80, the figure rises to 20%. The changes in population structure have consequently made the issue of decision making for those who

incapacity of adults, and the need to make medical decisions on their behalf, had turned the issue into a societal problem, and ensured government attention.

The extent of the response to the consultation paper confirmed the perception of need.³ Submissions were received from charities working on behalf of people without capacity, from local authorities, doctors, professional organisations, those working with the law, and – in large numbers - from members of the public, many of whom had personal experience of caring for a person without capacity.⁴

Conceiving the remedy: Perhaps if government action was prompted by perception of a problem for society, it should not be surprising that the remedy was also conceived as a social one. Although it was axiomatic throughout the legislative process that statutory provision should aim to protect vulnerable people,⁵ such an aim has to be pursued in context. There was never any intention of relieving the burden of incapacity by a state assumption of responsibility: extending the provision of public care, and revisiting the care in the community philosophy was not on the agenda. There was to be no nationalisation of the issue.

Equally, there was no appetite for formality. On the contrary, the intention was to provide for the management of incapacity wherever it arose in the ordinary course of life, by whoever found responsibility landing on them, and therefore particularly in the absence of institutionalised care.⁶ The very format in which

become incapacitated increasingly important.’ The Regulatory Impact Assessment of the Mental Capacity Act refers to dementia affecting ‘over 700000 people in the UK’ and the expectation that this will rise to 850 000 by 2010.

³ The government took this as ‘confirm[ation] that this is an important area of social policy which has a significant effect on the daily lives of many people.’: introduction para 3.

⁴ *Making Decisions*, introduction para 2

⁵ See para 1.3 of the Code: “The underlying philosophy of the Act is to ensure that any decision made...on behalf of someone who lacks capacity to make the decision ... for themselves is made in their best interests.” Also para 1.4: “The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual’s right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.”

⁶ This is in marked distinction to most other jurisdictions, where protective measures are based largely on guardianship models, eg South Australia, Ontario, Scotland. ‘Guardianship’ models

the new regime is laid out – not just a dry piece of legislation, but also a simple language, user-friendly Code, complete with illustrative vignettes⁷ – is part of the message: the broad scope of the provisions which duly became the Mental Capacity Act applies to *everyone* who looks after or cares for someone unable to make decisions for themselves, including family members, however devoted or reluctant they may be.

The regulation of informal care of the mentally incapacitated could have been coercively motivated. A body of academic literature⁸ already contended that objective determination by a family of an individual member's best interests is unlikely to be possible; and further, that informal care-giving, and particularly families, ought to be recognised as generating a distinct set of moral obligations. Representations made to the Law Commission⁹ included the contention that voluntary family carers should not be expected to consider the interests of the cared-for person to the exclusion of the interests of anyone else; and the government explicitly asked whether relatives and carers could be expected to put the interests of the incapacitated first.¹⁰ In response, with the protective intention in mind, an attitude of compulsion would not have been surprising.

Instead, the attitude struck was one of support. The Secretary of State prefaces the Code with a declaration that

“for many people, the most important relationships will be with the wide range of less formal carers, the close family and friends who

focus predominantly on the procedure for delegating powers to a substitute decision-maker, rather than on the procedures through which substitute decision making should be operationalised. Although the authority to intervene is closely regulated, the decisions made upon intervention are not. (See Dunn et al p118)

⁷ Intended to be more user-friendly than traditional, dry descriptions of law, these fictional ‘case studies’ un(?)wittingly reveal something of the DCA preoccupations behind the new law. In particular, it will be suggested later in this chapter that the vignettes chosen to illustrate how the new provisions should be interpreted reveal a background suspicion of families and family involvement in decision-making.

⁸ Buchanan & Brock 1998, Hill-Smith 1998, see earlier chapters.

⁹ *Mental Incapacity* (LC 231) para 3.31.

¹⁰ *Who Decides?* Para 3.24: Q11iii

know the person best, some of whom will have been caring for them for years.”¹¹

Even before the Code was published, academic commentary noted in the draft provision, an ethos of support for social and caring networks. Peter Bartlett saw that the ‘general authority’ “in most cases allows anyone to make a decision”; and pointed to the lack of any requirements to comply with formalities or give notification.¹² Kirsty Keywood saw the provisions as ‘validating the decision-making role of those closely involved in caring for the person without capacity.’¹³

A role for the family? The legislation was built, then, on twin pillars of intent: protecting the vulnerable, and supporting their care networks. Unfortunately, while these are related goals, they may also be conflicting. The forum where the incompatibility of the statutory aims will be realised is the family, as the respondents to the Law Commission made clear. The family is the care setting where interests become interdependent, and it is no longer possible to make a life-choice for one member without impacting on the life choices of others. In those circumstances, it is important to ask what substance there is to the professed support of family relationships and their special characteristics.

The very generality of the Secretary of State’s declaration, and the universality of the ‘general authority’, reveal the absence of *real* consideration of the special interests of families, as distinct from other types of caregiver. In their designation as ‘family carers,’¹⁴ it is apparent that the only way the family is conceived within the statutory provisions is as a subset of carers. The inclusion of families is generic only, with no recognition of the factors which, as we have seen in earlier chapters, in truth distinguish them from other carers.

¹¹ Foreword, fourth paragraph.

¹² ‘*Adults, Mental Illness and Incapacity: Convergence and Overlap in Legal Regulation*’ [2003] Journal of Social Welfare & Family Law 25(4) 341-353 at 347.

¹³ ‘*Gatekeepers, Proxies, Advocates? The Evolving Role of Carers under Mental Health and Mental Incapacity Law Reforms.*’ Journal of Social Welfare and Family Law 25(4) 355-368 at 360.

¹⁴ See p2 of the Secretary of State’s Foreword, paragraph 4.4 and frequently thereafter in the Code.

This underlying attitude to family relationships is revealed both in the specific provisions of the Act¹⁵ and in its general scope. Although the provisions apply to anyone in the position of *giving* care, they are not so universally applied to anyone in need of *receiving* it. The Mental Capacity Act provides only for incapacitated persons over the age of sixteen. The care and treatment of children – who lack capacity automatically by virtue of their age and immaturity - is still generally to be determined according to common law principles.¹⁶ A major area of family life, where medical decisions have to be made for others, is clearly not affected at all by the new legislation.

As children mature, the teenage years of uncertain competence are further complicated by statutory indecision: for young people between the ages of 16 and 18, there is an overlap between the Mental Capacity Act and the Children Act 1989, with no rules to determine the selection of jurisdiction. The MCA Code suggests that the question of a young person's capacity is medicalised. Cases of incapacity by reason of mental impairment or disturbance, and cases of medical treatment disputes between doctors and families of a young person aged 16-18, would be appropriately referred to the Court of Protection.¹⁷ However, social incapacity cases - for example, where a young person is simply overwhelmed by the magnitude of the treatment decision – and cases of a young person's competent *refusal* of treatment, would still be referred to the Family Division of the High Court.¹⁸

The potential for distorted judicial assessments of youthful capacity for benevolent ends is therefore still as ripe as we previously found it to be. The impact of the new statutory provisions on young people will depend on the extent to which the new statutory approach proves different to the common law in its approach to families. If the new statutory provisions simply replicate the

¹⁵ See later

¹⁶ See page 216 and para 12.2 of the MCA Code. The two exceptions to this are not relevant to consideration of medical treatment decisions. Cases in respect of young people aged between 16 and 18 may be heard either in the Court of Protection or in the Family courts, with powers of transfer between them.

¹⁷ Para 12.7

¹⁸ Para 12.14

old approach to family, then they have introduced regrettable procedural complexity for no gain. On the other hand, if the statutory provisions approach families differently, the probability of anomalous decisions looms. When a treatment decision has to be made for a young person, it would be curious if the family role in the decision-making process were to be different according only to the physiological basis of the need for substitute judgment: a young person is still a young person, and a family is still a family, by whatever medical necessity they find themselves in need of treatment.

The Five Statutory Principles: The Act begins with a statement of five principles¹⁹ which underpin its provisions. They summarise, in essence, the philosophical approach behind the practical provisions. Consequently they reveal much about the role of the family, as perceived by legislators. So fundamental are they that it is worth setting them out in full:

- a. A person must be assumed to have capacity unless it is established that they lack capacity.
- b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- d. An act done, or decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- e. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as

¹⁹ Section 1

effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The focus of these principles is clearly the person who lacks capacity, which in itself tells us something about the approach which the Act takes to families. The message of the principles, as the Code tells us,²⁰ is that the Act is intended to be “enabling and supportive of people who lack capacity, not restricting or controlling of their lives.” The intention in respect of those who are expected to do the enabling and supporting, how restrictive or controlling of *their* lives the legislation is intended to be, is much less clear.

The general authority: Families become actors in the legislative drama when these principles come to be put into effect. The Act gives a general authority to act whenever anyone does an act in connection with the care or treatment of an incapacitated person,²¹ as long as he does so reasonably believing that it is in that person's best interests.²² Legal authority arises simply from undertaking the task, irrespective of medical qualification or familial nexus. This is the embodiment of the statutory intention to provide for management of incapacity wherever it arises in the ordinary course of life. Clearly the general authority extends to families in the ordinary course of family life, but it is in no way special to families.

Wide though it is, right from the outset the general authority was to have limits. The Law Commission recommended a category of cases which would always require court approval, and that recommendation is reflected in paragraph 6.18 of the Code, which lists decisions which must be referred to the Court of

²⁰ Chapter 2, first paragraph.

²¹ But the incapacity is decision-specific, as the first principle and its explanatory notes in the Code make clear. (In the scenario on page 21 of the Code, Mrs. Arnold has capacity to deal with everyday financial matters, but not difficult investment decisions.) So the range of actions permitted under the general authority will differ according to where the patient currently sits on the incapacity spectrum: more intrusive actions will be permitted by the carers of a pvs patient than by the carers of a patient in the early stages of Alzheimer's. For patients at the boundaries of competence, it will be difficult to know precisely when and to what extent carers will be permitted to step in. For an interesting discussion, seeking to 'blur the line', see Herring's 'Losing it? Losing What? The Law and Dementia.', King's College Lent Lectures.

²² MCA s5. And as long as he does the act competently of course – there is no protection from negligence.

Protection: withholding or withdrawal of artificial nutrition and hydration in a pvs patient, organ or bone marrow donation, and non-therapeutic sterilisation.²³ Not surprisingly, these are issues which raise questions of ethical unease or dilemma, and for which the court had carved out its inherent jurisdiction in the first place. There is nothing in the Act or the consultation papers which suggests that the Court of Protection will or should approach these matters any differently to the High Court under the inherent jurisdiction. Rather, the discussion documents seem to endorse the observations of the judges.²⁴ In the most significant of matters then, the role of families is unchanged.

Even in less significant matters, the general authority extends to *anyone* performing an act of care or treatment of the incapacitated person. This will include other carers, including paid carers and, of course healthcare professionals. It is the person performing the act or administering the treatment who must satisfy the statutory requirements, and must therefore believe that what he does is in the best interests of the incapacitated person. What role does that give the family in influencing decisions?

The decision-making framework: In making a decision about the best interests of an incapacitated person, the decision-maker must follow the steps laid out in section 4²⁵ of the Act. In particular, pursuant to section 4(7), he must take into account the views of certain people. Without separate identification, family members will usually fit easily into the requirement to consult *anyone engaged in caring for an incapacitated person, and close relatives if they take an interest in his welfare*,²⁶ if it is practical and appropriate to do so. Consultation is of course not decision-making, and even so the obligation to consult families is not absolute, but the expectation should be that that the family is consulted *unless*

²³ The recommendations of the Law Commission had been more nuanced. They reflected the same concern for supervision of medical values as drove the House of Lords in *Re F*, in the further suggestion that the Secretary of State be given power to prescribe additional treatments which should require court authorisation – ‘so that changes in medical science may be taken into account.’ The Code can of course be amended and updated without amendment of the Act, so perhaps the same objective is achieved.

²⁴ For example, the Law Commission report reiterates the comments of Lord Mustill in *Bland* (para 6.17)

²⁵ See appendix 4.

²⁶ See Code p66. A relative’s interest may, by implication, be short of actually caring for him.

there is good reason not to. The legislation has made space for families at the outset.

In the consultation process, family members are invited to give two distinct types of information: firstly a recount of the incapacitated person's own wishes and feelings, beliefs and values, and secondly their own views about his best interests. The first amounts to a recognition that the family has intimate²⁷ knowledge of the incapacitated person, which is a matter of value to decision-makers. No one else is likely to have known the patient as well, or as long, and so be as informed about his wishes and feelings, beliefs and values. The second type of information is notably *their* opinion of the patient's best interests (as distinct from their best guess of what he would choose now if he could). So, when the family does not hold decision-making power, it has at least been given a legitimate voice.²⁸

Families and IMCAs: There are indications in the Act that whatever this voice has to say must be worth listening to, for wherever there is no family to speak, the statute creates a surrogate – the Independent Mental Capacity Advocate. There is a clear link between families and IMCAs – the absence of one is the catalyst for appointment of the other²⁹ – but they are not equivalents.

The IMCA was conceived as a result of the many responses to the consultation paper which raised the issue of the role of advocates in supporting the rights of a person without capacity and assisting them in making decisions.³⁰ The IMCA's role is 'to support the person who lacks capacity',³¹ to provide information to help work out what is in the person's best interests, and to raise questions or

²⁷ But it does not recognise their knowledge of the patient as *unique*, since the same consultation process applies also to anyone 'engaged in caring for the incapacitated person' – even if their involvement has been only recent, and started without any prior knowledge of the patient, as is often the case with paid carers.

²⁸ The Law Commission report which preceded the statute 'saw the force of argument' that "family members should be made visible in the new statutory scheme." (para 3.33)

²⁹ See MCA Code pg 66 and para 10.42

³⁰ *Making Decisions?* Para 21

³¹ Code pg 179

challenge decisions which appear not to be in the best interests of the person.³² These responsibilities reasonably reflect the expectations of a supportive family.

However IMCA's powers go further: they 'represent' the person without capacity in discussions to determine their best interests³³ and they *must* be consulted. To help them do their job, they are allowed access to relevant healthcare records and social care records.³⁴ In contrast, family members are not conceded powers of advocacy, the obligation to consult is qualified by considerations of practicality and appropriateness,³⁵ and rules of confidentiality would normally prohibit their access to records.

The contrast between the powers of families and of IMCAs suggests that the system expects more of families than it gives them credit for. The creation of an advocate where there is no family suggests that we expect families to advocate on behalf of their incapacitated members, without officially recognising that role, and even hampering its performance with restricted access to information. Family support is valued, but family members are not trusted.³⁶

The implications of consultation: In reality, a voice is of little use unless it is heard and allowed to influence the decision-making process. The weight to be

³² Code para 10.4

³³ Code para 10.4

³⁴ Code para 10.5

³⁵ Where it is not practical or appropriate to consult family members, an IMCA must be appointed for serious medical decisions and care moves: Code para 10.77

³⁶ There are two mechanisms under the Act by which the position of family members may be strengthened. Holding a Lasting Power of Attorney (which can now cover personal welfare, including healthcare and consent to medical treatment: Code para 7.3) empowers family members – for then, it is not a matter of trust at all, but a competent decision of the patient himself. Alternatively, if no LPA is in place and there is an ongoing need for decision-making powers on serious questions of healthcare or personal welfare, the Court of Protection may appoint a Deputy who will in most cases be a family member (Code para 8.33). This latter, however, is envisaged as a device not just for promoting family involvement (Code para 8.39 and scenario p250), but also for excluding it. Paragraph 8.39 of the Code also envisages the appointment of a Deputy where 'there is a history of serious family disputes that could have a detrimental effect on the person's future care' and where 'the person who lacks capacity is felt to be at risk of serious harm if left in the care of family members.' The power of exclusion is arguably the more powerful, because exclusion cuts off family involvement in decision-making, whereas involvement is only to the usual standard of the *patient's* best interests). Moreover, the real power inherent in either of these roles may be illusory. Decisions made under the general authority may not be inconsistent with decisions made by holders of LPAs or by Deputies, but it is not necessarily clear that the individual exercising the general authority would always know of such managers or attorneys, or of their decisions.

attached to the family's views is a matter for the decision-maker to determine. In the explanations of the statutory principles which is offered by the Code, there can be detected a background suspicion of families. The 'case studies' which are intended to facilitate lay interpretation of the legislation may unwittingly reveal Department of Constitutional Affairs preoccupations. The second principle, for example, is illustrated by a scenario in which the patient's mother is depicted as forcing onto her daughter her own opinions and experiences of ECT:

"Sara, a young woman with severe depression, is getting treatment from mental health services. Her psychiatrist determines that she has capacity to make decisions about treatment, if she gets advice and support. Her mother is trying to persuade Sara to agree to electro-convulsive therapy (ECT), which helped her mother when she had clinical depression in the past."³⁷

In marked contrast, it describes the psychiatrist providing "factual information about the different types of treatment available and explain[ing] their advantages and disadvantages...[and] how different people experience different reactions or side effects." It concludes by drawing a clear distinction between "what is right" for the patient and "the personal opinions of her mother".

Similarly, the third principle is amplified with a declaration of support for an individual's right to disagree with their family:

"Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends or healthcare or social care staff are unhappy with a decision."³⁸

³⁷ Code, pg 24.

³⁸ Para 2.10

The implication is that the principles are to be operated as a bulwark against overly officious families, for the good of the individual.

That implication is not limited to the general philosophy behind the Act. Where the Code explains the operation of its provisions, the same suspicion is imported. The scenario conjured to illustrate an assessment of capacity,³⁹ for example, depicts an 82 year old woman recovering from a stroke, and her daughter attempting to extract information from her consultant to further the daughters' view of where the old lady should live – and in dispute with her brother to boot! And where the Code explains the duty to consult family members in the determination of best interests, it is the potential for conflicting interests which is emphasised:

“People with conflicting interests should not be cut out of the process (for example, those who stand to inherit from the person’s will may still have a right to be consulted about the person’s care or medical treatment). But decision-makers must always ensure that the interests of those consulted do not overly influence the process of working out a person’s best interests.”⁴⁰

The ‘insight’ families may ‘sometimes’⁴¹ have is apparently downplayed by comparison to the ‘specialist knowledge’⁴² of paid care workers and even voluntary sector support workers. After all, the approach to families implied by the Code of the Mental Capacity Act seems surprisingly reminiscent of the older approach in the Code to the Mental Health Act 1983.⁴³

³⁹ Pg 45: “Mrs Collins is 82 and has had a stroke...She is living in a house that has been the family home for years. Her son wants her to sell her house and live with him. Mrs. Collins likes the idea, but her daughter does not. She thinks her mother will lose independence and her condition will get worse. She talks to her mother’s consultant to get information that will help stop the sale.”

⁴⁰ Para 5.67

⁴¹ Para 5.65

⁴² Para 5.66

⁴³ The old provisions of Mental Health Act 1983 were limited to providing Nearest Relatives with basic information, and even then the obligation was not absolute: MHA83 Code of Practice: 2.27 -2.31. The family was to be viewed with suspicion, rather than as an ally. Para 3.24 warns “In particular, the medical profession should be cognisant of the possible conflicting roles of informants, including the possibility of disagreements among those who

Taking all this together, undoubtedly the role of the family implicit in the general philosophy of the Act is limited. The family is only considered as a mouthpiece of the patient and opinion holder, and not as bearers of mutually dependent interests that deserved consideration in the assessment of that patient's best interests. The family is still not part of the treatment equation, but merely of instrumental use: can it help the patient 'make choices or express a view,'⁴⁴ or can it 'provide valuable background information'?⁴⁵ Specifically, family members' views and wishes about what *they* would want for the person must not influence the assessment,⁴⁶ and nor should any consideration of the implications of the decision for the family unit.⁴⁷ As far as families are concerned, the blindness of the common law seems to have been replaced only by the partial-sightedness of legislation.

'Best interests' Considerations.

It is a medical commonplace that impairment of sensory perception in one area may be compensated by enhanced sensitivity in another. In the interpretation of the Mental Capacity Act, it could be that the influence of the family in substitute decision-making for one of its members works in the same way. The general authority to act is dependent on an assessment of the incapacitated person's *best interests*. If it is excluded from the focus of deliberations, could the family nonetheless be given a more influential role by means of a more sympathetic concept of 'best interests' in the new statute?

are consulted;... and the subjectivity, both of the criteria, and of relatives and carers who are required to make the necessary judgments." Family subjectivity is assumed to be a bad thing, and there is no recognition at all of the impact of one member's incapacity on the wider family.

⁴⁴ Code para 4.36

⁴⁵ Code para 4.49

⁴⁶ Code para 4.49

⁴⁷ For this reason, Choudhry's prediction (in 'Best Interests in the MCA 2005 – What Can Healthcare Law Learn from Family Law?' (2008) *Health Care Analysis* 16 240 at p248), that the 'best interests' test under the Mental Capacity Act 2005 is less likely than its parallel provision under the Children Act to be 'hijacked' by other parties presenting their own interests under the guise of the patient's/child's, may perhaps be over-optimistic. Being consulted for one's view of another's 'best interest' is a long way short of having one's own interests taken into consideration. If family interests are still not part of the assessment, then in order to pursue influence, exactly the same temptation to 'hijack' persists.

Just as under the inherent jurisdiction, the ‘best interests’ of the person for whom a decision has to be made is the key element of substitute decision-making under the Act. The common law powers had been dominated right from the outset by the notion of ‘best interests’, to the extent that it would be easy to assume that it was a jurisprudential prerequisite of decision-making. It is not.⁴⁸ The notion of ‘best interests’ originated, as we have seen, in the doctrine of necessity. Incrementally, as cases demanded, its application was widened to other invasive medical decisions, and latterly to non-medical matters thought to impact on welfare.⁴⁹ By these steps the ‘best interests’ benchmark simply became so pervasive in England and Wales that it extinguished debate, and its continuation as the base line in the new legislation was never in doubt, or seriously questioned.⁵⁰

The leap of imagination which the Mental Capacity Act achieved, however, was to turn such an individual concept into a universally applicable benchmark. The new legislation standardised ‘best interests’ by eschewing any reference to necessity. Instead, it answered the ethical debate between substituted judgment and individual interests with a unitary framework which incorporates both.⁵¹ The ‘best interests’ of the person who cannot make a decision for themselves becomes both the reason and the authority for substitute decision making.⁵² The Mental Capacity Act does not just reject the old argument between substituted judgment and best interest approaches; it forces them into an arranged marriage. Then, by extending substitute decision-making to any health, welfare and

⁴⁸ Other jurisdictions adopt a substituted judgement approach, in marked contrast to ours.

⁴⁹ See Dunn et al, “Constructing and Reconstructing ‘Best Interests’: An Interpretative Examination of Substitute Decision-Making under the Mental Capacity Act 2005”, [2007] 29 J Social Welfare & Family Law 117-133 at p119

⁵⁰ “There is little doubt that decisions made on behalf of a person without capacity should be made in their best interests. Respondents to the Law Commission’s consultation almost unanimous in their acceptance of this point, and the government shares this view”: *Who Decides?* Para 3.22. So when the Code was published, it boldly stated at para 1.3 that the “The underlying philosophy of the Act is to ensure that any decision made...on behalf of someone who lacks the capacity to make the decision...for themselves is made in their best interests.”

⁵¹ Determinations that are not in fact in the best interests of the person for whom they are made only attract liability if the decision-maker fails to demonstrate that he has adhered to the requirements of the best interests checklist.

⁵² In the words of Dunn et al, ‘the *justification* for making decision-specific interventions’ (p118) (*Italics added*). The linking of both substitute decision-making authority and the best interests model is called “the appropriation of an objective accounting approach by subjective considerations” (p126).

financial decision, the legislation turns ‘best interests’ into “a universal mechanism for determination, applicable regardless of the decision-making context.”⁵³ What started as a judicial tool of medical decision-making *in extremis*, becomes a general model for everyday health and social care.

The difficulty with such a generalised concept is – and always has been – identifying it in specific cases. As Gurnham⁵⁴ points out, the Act does not actually define ‘best interests’; it merely provides, in the form of the section 4 ‘checklist’, a framework for working it out in any given case. Just as the common law widened over time the issues to be determined by the ‘best interests’ benchmark, so too did it expand the understanding of what constituted ‘interests’ at all. Originally, the focus was on *medical* interests, but it came to encompass emotional and other interests too. The progression of the concept was – as we have seen – “inconsistent and non-linear....fluid and idiosyncratic,”⁵⁵ producing a number of anomalous decisions, and (as I have argued) generally failing to recognise interests embedded in familial relationships, but it was progression nonetheless.

Since legislation in general has such a long gestation period, it was inevitable that the common law progression would continue whilst statutory reform was being debated and decided.⁵⁶ Both time, and the non-linear nature of common law development, made sure that whatever concept statute adopted would be a matter of choice, not of inevitable conclusion: as Dunn puts it, the concept of ‘best interests’ encapsulated in the Mental Capacity Act therefore “reflects, but is not the culmination of,”⁵⁷ the common law progression. The question behind the

⁵³ Dunn et al p122

⁵⁴ In “‘Reader, I Detained Him Under the Mental Health Act’: A Literary Response to Professor Fennell’s *Best Interests and Treatment for Mental Disorder*” (2008) *Health Care Analysis* 16 268 at p275.

⁵⁵ Dunn et al, *ibid* p 122

⁵⁶ This can be seen in the Law Commission’s report which began the legislative process. At paragraph 3.26, it envisaged recommendations which would “probably involve a significant departure from the present state of the law. This, as set out in *Re F*, appears to provide that a doctor who acts in accordance with an accepted body of medical opinion is both (1) not negligent and (2) acting in the best interests of a patient without capacity.” The common law had moved substantially beyond this position by the time the Mental Capacity Bill was presented to Parliament.

⁵⁷ Dunn et al, *ibid* p 122

legislation was where in the process of development to step in: which concept of best interests to entrench?

From the outset, with the Law Commission's report in February 1995,⁵⁸ legislative reform advanced a patient-centred concept of 'best interests'. It was

“designed to ensure that any substitute decision is taken at the lowest level of formality which is consistent with protection of the person without capacity, both from the improper usurpation of his or her autonomy and from inadequate or even abusive decision-making.”⁵⁹

The focus was on “the *individual* welfare of the person to whom [the benchmark] was applied.”⁶⁰ There is no recognition of interdependency here.⁶¹

On the other hand, the perception of the person without capacity for whom decisions have to be made is quite holistic. When the decision-maker is undertaking his deliberations, section 6 (a) – (c) and the Code's 'quick summary' of how to go about it direct him to 'identify all the things that the person who lacks capacity would take into account if they were making the decision or

⁵⁸ 'Mental Incapacity', Report no. 231.

⁵⁹ LC Report para 3.24

⁶⁰ Dunn et al, *ibid* p 121, italics added. Support for this view can be seen in the Law Commission's report at paragraph 2.46: “Our overview paper suggested that the aims of policy for this project should be:

(i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;

(ii) that where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and should be concerned to achieve what the person himself would have wanted; and

(iii) that proper safeguards should be provided against exploitation and neglect, and against physical, sexual or psychological abuse.

⁶¹ Choudhry has suggested (in 'Best interests in the MCA 2005 – What Can Healthcare Law Learn from Family Law?' (2008) *Health Care Analysis* 16 240 at p248) that the inherent incompatibility with Human Rights Act principles which dogs the paramountcy principle under the Children Act is not a difficulty for the Mental Capacity Act because “no ... hierarchy of interests exists”. If that is correct, it is only because you cannot have a hierarchy of one. Under the Mental Capacity Act, just as under the inherent jurisdiction, the patient is the *only* person whose interests are taken into account. Others may give their views of those interests (pursuant to s4(7)), but their *own* interests are specifically not part of the consideration. Since interdependency is, as I have maintained throughout, a feature of medical decision-making in reality, it seems only a matter of time before someone questions the compatibility of the Mental Capacity Act with HRA principles.

acting for themselves'. In particular, the decision-maker must ascertain the patient's past and present wishes and feelings; any beliefs and values that would be likely to influence his decision; and anything else he would be likely to consider, including the effect of the decision on other people, obligations to dependants or the duties of a responsible citizen.

The importance of matters other than the strictly medical is therefore enshrined. Physical wellbeing is not all that has to be considered. Non rational, even metaphysical, factors are given a place in the decision-making process. Evidence of those wishes, beliefs and values may be found, we are told, in the patient's 'cultural background, religious beliefs, political convictions or past behaviour and habits,'⁶² and the best authorities of such intangible characteristics are recognised to be those who are close to the person who lacks capacity, such as close family members.⁶³ The information families provide is of instrumental use only, but it is fundamental to the statutory concept of 'best interests', and its relevance to the ultimate decision is more assured than it was at common law.

Insofar as the statutory concept of 'best interests' has attracted academic commentary,⁶⁴ it has generally interpreted section 4 as a move to enhance patient autonomy. In particular, Bartlett sees it as strengthening the patient against the medics:

“Notwithstanding the language used, [what became s4] is a move away from a traditional 'best interests' test, where the decision is based primarily or exclusively on criteria considered important by the decision-maker, to a test which requires the past and present views of the person lacking capacity to be considered, as well as the need to buttress the autonomy of that individual. The criteria are

⁶² Code para 5.46

⁶³ Para 5.54

⁶⁴ Note in particular the special issue of *Health Care Analysis* (2008) volume 16, publishing papers from a conference considering the issue.

therefore a move away from a simple ‘doctor (or carer) knows best’...’⁶⁵

This interpretation *follows* the common law approach, at least as to the place of families in the process of determining a patient’s interests, and therefore was perhaps the orthodox interpretation to be expected in the early stages of the legislative process.

It does not however, indeed *could* not, take account of the Code, which was published very late⁶⁶ in the legislative process, but which purports to guide our interpretation of the statutory provisions. The Code gives encouragement to an interpretation which is far more sensitive to families.

The information which families are asked to supply can be seen as susceptible to recognition of interdependency. “Wishes and feelings ... beliefs and values”⁶⁷ are indeed pertinent to autonomy, but they may equally encompass an ethic of care. The evidence of the ‘cultural background, religious beliefs, political convictions or past behaviour and habits’ in respect of patients embedded in families will demonstrate the mutuality of relationships, and – from the fact that the patient did not choose to reject his family and live instead as a hermit – that he placed a value on that mutuality.

As a matter of statutory interpretation, s4 gives no grounds for valuing a person’s self-interest over his selflessness, his concern for himself over his concern for others. The Code states expressly that the other factors of s6(c) ‘might include the effect of the decision on other people, obligations to dependant or the duties of a responsible citizen,’⁶⁸ For any patient who lives within a family, the statutory concept of ‘best interests’ can be construed as recognising the mutuality of his relationships – the obligations which they entail, as well as the benefits which they bestow. The recognition of values and habits, in a

⁶⁵ ‘Adults, mental illness and incapacity: convergence and overlap in legal regulation’ [2003] Journal of Social Welfare & Family Law 25(4) 341-353 at 348.

⁶⁶ Not until 23rd April 2007

⁶⁷ MCA 2005 s 4(6)(a) and (b)

⁶⁸ Code para 5.47

framework which accepts non-rational motivations, opens the way for recognition of family interests. As the Code makes clear:

“The Act allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity to make the decision. For example, having considered all the circumstances of the particular case, a decision might be made to take a blood sample from a person who lacks capacity to consent, to check for a genetic link to cancer within the family, because this might benefit someone else in the family. But it might still be in the best interests of the person who lacks capacity. ‘Best interests’ goes beyond the person’s medical interests.”⁶⁹

Of course the patient is still the focus of the determination here, and is protected from abuse. “*As long as they are in the best interests of the person who lacks capacity*” is a vital caveat. In effect, the consideration of anyone’s interests other than the incapacitated person’s alone, is admitted *by consent*. Only if the patient can be shown in the past to have been motivated by consideration of the impact of his behaviour or condition on his family, can that be considered now in his incapacity. The bullying overlord of his downtrodden family cannot suddenly be expected to consider their wellbeing once he loses capacity; and the simply unthinking will not be credited with insight.

The weakness of this interpretation of statute, however, is that although altruism may be recognised, it cannot be compelled. In truth, it is the patient’s family interests which may be admitted, not the patient’s family’s interests.

Caution on behalf of families is reinforced by examination of the common law authorities to which we are referred for guidance. The Code illustrates the statutory provisions on this point by reference to *Re Y (Mental Incapacity: Bone marrow transplant)*⁷⁰ and *Re A (Male Sterilisation)*.⁷¹ As previously seen, *Re Y*

⁶⁹ Code para 5.48

⁷⁰ [1996] 2 FLR 787, at footnote 17 of the Code.

⁷¹ [2000] 1 FLR 549, at footnote 17 of the Code.

concerned a medical procedure of relatively modest invasiveness, was hedged about with judicial cautions and caveat, and still attracted criticism as a step too far. In *Re A* the proposed treatment was refused as not in the patient's best interests. The Code does not refer to *Re T*, which is generally seen as a high-water mark of family considerations determining best interests, but that may be of course because the case concerned an infant, outside the scope of the Act in any event. The caution intrinsic to the cited cases seems to make clear that, although there may be increased openness to arguments of a patient's family interests, judicial interpretation of the threshold of best interests, should it come to that, is not likely to have shifted dramatically.

The emphasis of the Act is not, however, on judicial interpretation. The 'best interests' determination is to be carried out by whoever has to make the decision in question, almost certainly not a legally qualified person, and in matters of care at least, very often not medically qualified or experienced either - often, in fact, a family member.

In those circumstances there is no reason to assume that everyday decisions will automatically reflect common law decisions. A decision-maker's determination of best interests has to be objectively reasonable, but not necessarily the same as a judge's. The 'best interests' checklist may reflect the discursive interplay of judicial deliberations up to the time of statutory drafting, but its path of progression thereafter is put very largely outside judicial control. Other characters are likely to have much more impact on how the new Act is applied, and family members who care for their incapacitated relatives are therefore in an altered position of influence. In matters of everyday care at least, such as appropriate clothing or whether to apply a sticking plaster, decisions are effectively delegated to family or carers. There is every likelihood that, in such matters of everyday care, family decision-makers will afford different elements of the best interest checklist greater weight.

In relation to medical treatment, however, the impact of this should not be overstated. Wherever any *significant* treatment decision has to be taken, there is likely to be a clinician involved, who assumes the role of decision-maker simply

from the fact that his is the expertise recommending the treatment. Even as doctors are bound by the Act, the foundation of their reasonable belief as to the patient's best interests will be clinical judgment informed by their obligations as a doctor, set out in GMC guidance. The guidance document, 'Consent: Patients and Doctors Making Decisions Together',⁷² does not explore, still less attempt to define 'best interests'. It refers to the Mental Capacity Act, and sets out medical obligations in the following terms:⁷³

75 In making decisions about the treatment and care of patients who lack capacity, you must:

- (a)** make the care of your patient your first concern
- (b)** treat patients as individuals and respect their dignity
- (c)** support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care
- (d)** treat patients with respect and not discriminate against them.

76 You must also consider:

- (a)** whether the patient's lack of capacity is temporary or permanent
- (b)** which options for treatment would provide overall clinical benefit for the patient
- (c)** which option, including the option not to treat, would be least restrictive of the patient's future choices
- (d)** any evidence of the patient's previously expressed preferences, such as an advance statement or decision

⁷² Effective as of 2nd June 2008

⁷³ This is in marked contrast to the guidance in respect of patients aged 0-18, which provides at paragraph 12 that "An assessment of best interests will include what is clinically indicated in a particular case. You should also consider:

- a. the views of the child or young person, so far as they can express them, including any previously expressed preferences
- b. the views of parents
- c. the views of others close to the child or young person
- d. the cultural, religious or other beliefs and values of the child or parents
- e. the views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare
- f. which choice, if there is more than one, will least restrict the child or young person's future options."

- (e) the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them
- (f) the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed treatment to be in the patient's best interests
- (g) what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

Medical assessments of best interests, it may be assumed then, will continue to be patient-centred and focussed on clinical interests. The requirement to consider family views at 76(f) is an information-gathering, rather than a decision-sharing, exercise. The prevailing medical culture, which undervalues family interests, is apparently unmoved by the new legislation.

Clinicians are not always so averse to treating patients with an eye to the advantage of others. It was as a result of representations by medical authorities that the Law Commission report and the government consultation paper which preceded the Mental Capacity Act raised the issues of genetic screening and elective ventilation,⁷⁴ asking whether these procedures, favoured by many doctors, were “ethical and reasonable”. Framing the best interests test of the statute to exclude consideration of the interests of others effectively answered that question negatively. The only exception which the statute permits relates to non-therapeutic research on the mentally incapacitated, which s30 permits within safeguards. Strikingly, one of those safeguards is the duty to consult the family, at least in as far as they are caring for the patient or interested in his welfare. If the family provide the information that, in their opinion, the patient would not wish to be involved in the research, then the patient may not be involved.⁷⁵ In this context alone, the family has the upper hand over the doctors.

⁷⁴ See paragraph 5.33, *Who Decides?*

⁷⁵ Section 32(5)

In summary, consideration of both the broad philosophy and the specific provisions of the Act suggest that the new legislation may admit recognition of interdependency in day to day matters where the family is the decision-maker; but resists it in the more significant and medical matters, where others assume decision-making roles. Exactly where the impact of interdependence is likely to be greatest, the family role is most limited. Despite the ‘visibility’ of the family within the statutory concept of ‘best interests’, a patient focussed approach and the prevailing medical culture combine to resist the potential for the family assuming any greater influence in disputed medical decisions than it played at common law.

In this context, academic criticism of the Act may now be considered. Dunn et al⁷⁶ were not exclusively concerned with the role of the family but they identified three potential problems⁷⁷ with the legislative approach to best interests, all of which will be realised in the family context.

Their first concern was that the ethical dilemmas inherent in some substitute decisions remain, and are highly emotive and controversial. As a result, there will continue to be inconsistencies in the ways in which ‘best interests’ are conceptualised and determined.⁷⁸

Inconsistency of outcome is itself an undesirable quality in law but in matters of human individuality – such as health – it can be defended as preferable to inflexibility.⁷⁹ The achievement of consistency by adherence to particular

⁷⁶ “Constructing and Reconstructing ‘Best Interests’: An Interpretative Examination of Substitute Decision-making under the MCA 2005” [2007] 29 J Social Welfare & Family Law 117-133

⁷⁷ Namely, a “fail[ure] to adequately resolve certain ethical dilemmas;...reduc[tion of] applied substitute decision-making to a series of compulsory generalised instructions; [and]...necessitating deliberation but offering little practical guidance to the process of determination.” (abstract)

⁷⁸ Pg 128. They cite the *Wyatt* case as an illustration of social controversy: the large scale media and public interest demonstrated an absence of consensus that the best interests benchmark was even an acceptable test to apply. *Wyatt* is a questionable illustration for discussions of the Mental Capacity Act, which does not apply to children. Perhaps it would be more helpful to consider the issues raised in *Burke*.

⁷⁹ The same criticism is traditionally thrown at the Matrimonial Causes Act 1973, but it has stood the test of time much better than its formulaic (and therefore predictable) counterpart, the Child Support Act.

outcomes would quickly provoke outcry in matters as individual and context-dependent as medical treatment decisions. Personal and particular decision-making is at the very heart of the ‘best interests’ concept and inconsistency is an inevitable corollary of that.

Dunn et al are not, however, objecting to inconsistency *per se*, as a public issue of predictability, one case compared to another. The problem they highlight is the unpredictable impact of the decision-making setting on the ‘best interests’ conclusion:

“The MCA reflects the common law in conceiving substitute decision-making within an individual relationship, specifically the doctor-patient relationship, or in a detached, consultative setting, such as a case conference. However, this conceptualisation of ‘best interests’ potentially gives rise to tensions, not only when other people’s interests are integrally connected with the outcome of the decision (see *Re Y*), but also when ‘best interest’ determinations are made in social settings, such as family or group homes. Maximising the ‘best interests’ of one individual in these settings may not be beneficial to, and may even impact negatively on, the ‘best interests’ of others in the same setting.”⁸⁰

In other words, they complain that where a family member is decision-maker, the decision will be fraught with considerations of *other people’s* interests. This objection takes it as inevitable that decisions made in a family setting will reflect concern for how a decision made for one of its members impacts on others.

The observation of tensions inherent in social settings is not a matter of insight on the part of Dunn et al, revealing lack of forethought in the legislative drafters. It is nothing more, nothing less than the familiar conflict between an ethic of autonomy and an ethic of care. There will always be a tension between the interests of different people in the same social setting: that is the essential

⁸⁰ Pg 128

paradox of human relations and it was addressed right at the beginning of the legislative process.⁸¹ In framing the provisions of the Mental Capacity Act, allowing decisions to be made in a social setting was a positive decision, not an accident of drafting. Furthermore, our analysis of the Act suggests that family decision-making will be limited to the more minor decisions of everyday care. The highly emotive and controversial issues, where decisions will have a greater impact upon the lives of family members, necessarily involve third parties as treatment providers, and therefore decision-makers.

Moreover, it does not follow that from the admission of decision-making in a social context that Dunn's 'inevitability' (that decisions in reality *will* reflect consideration of the impact on others) is permitted. The statutory insistence that any decision must be made *in the best interests of the person without capacity* demonstrates that it is not. Open recognition of the mutual dependency of patient and decision-maker would have dissolved 'tension' into a mere 'balancing exercise', but such an approach was emphatically not adopted. Within the statutory 'best interests' assessment, the impact on others is only relevant one step further removed – namely on how that impact itself impacts on the patient. It is not permissible to consider that the burden of care if X did not have a hip operation would be too much for Y to bear. It is only permissible to consider whether X's best interests are better served by undergoing the surgery and returning to live with Y, or by refusing the operation and losing Y's care.

The question then remains, whether decision-makers in a social setting *can* make choices which comply with the legislation; or whether the inevitability which Dunn et al predict will become reality, with the individual focus of decision-making which the Act intended more honoured in the breach than the observance. This possibility lies behind the second problem identified by Dunn

⁸¹ At paragraph 3.33 of the Law Commission's report it is noted both that "a small number of respondents...regretted the fact that we had provisionally rejected the grant of decision-making authority as an automatic consequence of family relationship"; and that "a small number of respondents also challenged the idea that an unpaid family carer should have to act in the best interests of a person lacking capacity, when the carer's life and interests are intimately bound up with the other."

et al, namely the tension between a general framework and the specificity of actual substitute decision-making.⁸²

Their concern is that the codification of best interests into a statutory principle both *requires* decision-makers to approach their determinations with primary regard to their legal obligations, and *assumes* that this legalistic approach is compatible with the identities of and relationships between the decision-maker and the decided-for.⁸³ In other words, the Act expects families both to make individually focussed decisions and yet also to continue functioning as a network. Dunn et al challenge the implicit assumption that this is even possible, pointing out the absence of empirical data in support. The price of the assumption being wrong, they point out, is either failure to achieve robust assessments of best interests, or deterioration in the personalised quality of care, or both.

Dunn et al are right to identify the unspoken assumption on which the new legislation is founded, but the fears they articulate may be questioned. They may equally have pointed out the absence of data to *disprove* the assumption. There are no empirical studies which demonstrate that decision-makers within the family context *cannot* determine the best interests of their loved ones. As we have seen, there are arguments on which to base a claim that such decision-makers are in fact best placed to make such determinations, informed as they are by a familiarity with the patient, which no other decision-maker can claim. There are also empirical studies which demonstrate that family carers are generally overwhelmingly motivated by the urge to promote, not damage, the interests of their loved ones.⁸⁴ Indeed, even Dunn et al argue that best interests determinations *should* be contextual.⁸⁵ By placing the decision-making authority

⁸² Pg 129-130

⁸³ There is some recognition that care has inherent in it multiple layers of duty/ interest etc. At paragraph 3.25 of *Who Decides?* the government notes that a local authority social services dept and General Practitioners may have a responsibility towards a relative or carer as well as towards the person without capacity.. There is however no similar insight to the reality that a family is simply a microcosm of this.

⁸⁴ See previous chapter.

⁸⁵ At pg 129: "Empowering substitute decision making must be based within the personal and interdependent relationship between the decision-maker and the person for whom the decision is being made." On this, we can agree.

in family hands at all, the legislation implicitly accepts the force of such arguments.

In reality, it will never be possible to obtain empirical evidence to either support or disprove the assumption, because of the very subjectivity of the best interests test. When best interests were limited to *medical* interests, then the optimum course could be identified with relative certainty. Once the concept is expanded to include emotional and other interests, the optimum decision becomes much more open to interpretation and debate. Family decision-makers may still reach robust determinations of ‘best interests’, albeit that they weigh the various factors to be considered differently to the courts, and therefore reach different conclusions. Dunn et al complain that there is no relational element in the best interests determination,⁸⁶ but our analysis of statutory provisions is more generous. At least in the limited matters where the family is decision-maker, there is some scope for relational considerations.

The predicted consequences of Dunn et al’s second concern would so undermine the fundamental intentions of the Act, that any interpretation which avoids them should be given serious consideration. Their warning is more credible therefore, not as a criticism of the legislation as it must inevitably apply, but as an argument in favour of our interpretation of the decision making procedure.

The third objection of Dunn et al is that the legislation “aids deliberation not determination”⁸⁷ – that it provides the ingredients for the recipe, but not the means of cooking it. There are two constituent elements and a conclusion to this objection. First, it is pointed out that, having secured the revelation of conflicting values and opinions, the statute offers no means to resolve them. Clearly not all decisions can be referred to the Court of Protection for judicial review. Secondly it is said that the legislation fails to prioritise the numerous factors which it decrees to inform the best interests deliberation. This, however, is commended

⁸⁶ Pg 129 continues: “...yet this relational element forms no substantive part of the Mental Capacity Act’s provisions. Instead, a ‘best interests’ determination is a detached and reflective procedure that is potentially incompatible with the situated and embodied nature of the relationship within which the ‘best’ decision could be based.”

⁸⁷ Pg 130

not criticised⁸⁸ and indeed there are parallels in long-established legislation, such as section 25 of the Matrimonial Causes Act 1973. From these two observations it is concluded that the best interests principle may become defensively orientated, used to justify decisions retrospectively, rather than to guide them in advance.

This chain of thought fails to appreciate the non-interventionist approach implicit in the legislation and the consultation documents which led up to it. Conceiving incapacity as a social problem, a social solution was devised. The intention was to create a guidance mechanism, to ensure a basis for decisions that would be acceptable in an open and democratic society, without that society having to assume the burden of actual responsibility. Authority was always meant to rest with the judgment of the person who happened to be making the decision. It is not a conflict resolution device which the statute lacks, but the very concept of potential for conflict.

In the context of family care, this omission operates supportively if the family assumes full and exclusive responsibility, but dismissively as soon as they require help. The family of the Alzheimer's patient who is cared for at home will have much more control of decisions on his behalf than the family of a patient with the same symptoms but living in a nursing home. The true objection to this is that it is neither family nor patient focussed, but administration and cost centred.

Nor is it only this locus of decision-making authority which drives best interests considerations to a defensive orientation. The legislation was envisioned in defensive terms: it does not impose liability, but *excludes* it as long as procedural hoops are jumped. Yet there is nothing new in this. Far from being a novel feature of the Mental Capacity Act, defensive orientation has been an aspect of all legal adventures in this area since *Re F* itself, where judicial authority over

⁸⁸ "In contrast with recent common law declarations, the Mental Capacity Act offers no guidance to draw up a balance sheet. By not assigning priority to the elements that constitute the checklist, the decision-maker must only assess best interests with reference to the relevant circumstances in which he or she is making a determination This is a correct and commendable approach..." pg 131

medical decisions was won on the promise of protection from liability. In truth the Mental Capacity Act goes further to achieving proactive influence on the decision-making process than the common law ever did.

Taken together, the insights offered by Dunn et al's objections to the Mental Capacity Act support the interpretation of the new legislation as susceptible to interdependency considerations in the hands of family decision-makers, but not otherwise and even so only from the perspective of the incapacitated person. As far as family interests and the ethic of care are concerned, the brave new world of statutory regulation has brought very little change to the position reached by the common law.

Inherent Jurisdiction After the Act

Given the mutual shadowing of statute and common law, the fate of the inherent jurisdiction may be questioned. As far as the Law Commission was concerned, the new statutory jurisdiction was designed to replace the old declaratory jurisdiction⁸⁹ - indeed that whole jurisdiction was said to be 'makeshift' and 'temporarily in place pending the introduction of a coherent new statutory scheme'.⁹⁰ Avoiding the mistakes of the Children Act and the Mental Health Acts, it was specifically acknowledged that the court would retain its 'normal inherent jurisdiction' to make declarations as to lawfulness where the statutory scheme provided no remedy as a 'valuable safeguard', but it was hoped that recourse would be had to it very rarely. The government consultation paper followed exactly that expectation.⁹¹

Early academic commentary was not convinced. Peter Bartlett described the inherent jurisdiction as 'the wild card in the incapacity landscape'.⁹² In his view, the expansion of the inherent jurisdiction was the court 'claiming jurisdiction to make such decisions as may be required in the best interests of a person lacking

⁸⁹ *Mental Incapacity* para 8.6.

⁹⁰ *Mental Incapacity* para 1.3

⁹¹ *Who Decides?* Para 7.8

⁹² 'Adults, mental illness and incapacity: convergence and overlap in legal regulation' [2003] *Journal of Social Welfare & Family Law* 25(4) 341-353 at 351.

capacity’. Further, he perceives that the court saw that jurisdiction as ‘independent....separate from the previous case law which placed decisions in the context of other branches of law.’⁹³ Referring to the use of the inherent jurisdiction in Bournemouth-type cases,⁹⁴ he concluded that it is “far from clear that the jurisdiction will disappear....If it remains, and an ‘inherent’ jurisdiction may be remarkably difficult to get rid of, it is not clear how it will play off against legislative reforms.”⁹⁵

In the short time during which the Mental Capacity Act has been effective, the indications are that the courts have simply pursued the old ends under a new guise. We have already noted how use of the inherent jurisdiction continued to develop specifically in the context of deprivation of liberty⁹⁶ pending implementation of the Mental Health Act 2007 amendments to the Mental Capacity Act, to the point where it may be questioned whether there was any need for legislation at all. Since the new provisions came into force, the indications are that statute is simply being interpreted so as to comply with the former common law approach.

The case of *Surrey County Council v. MB*⁹⁷ was commenced under the inherent jurisdiction, but transferred into the Court of Protection for consideration under the Mental Capacity Act. The patient was lacking capacity. The medical witnesses wanted him to go to and remain at a particular medical unit, but they were unwilling to rely on the Mental Health Act, and had sought a declaration with compulsory effect instead. Charles J considered that s15(1)(c) of the Mental Capacity Act gave him discretion to make a declaration as to the lawfulness of their proposed action, in a free-standing provision which co-existed with the Mental Health Act provisions; and the statutory language was wide enough to include a declaration permitting compulsory removal and detention as long as it was found to be in the patient’s best interests, and complied with the conditions

⁹³ *Ibid* p351

⁹⁴ Specifically *Re TF (An Adult: Residence)* [2000] 1 MHLR 120

⁹⁵ *Ibid* p352

⁹⁶ *Re GJ, NJ & BJ (Incapacitated Adults)* [2008] EWHC 1097

⁹⁷ [2007] EWHC 3085, decided by Charles J on 9th October 2007

of *Sunderland v. PS*. Charles J was thereby acting under statutory authority, but as interpreted according to common law development – the tail wagging the dog!

This approach shows every sign of becoming entrenched. The principles of Charles J's judgment were referred to, agreed with, and followed by Sir Mark Potter P in *Re P (Adult Patient: Consent to Medical Treatment)*⁹⁸ :

P was a 22 year old man who suffered from severe, complex and presently uncontrolled epilepsy. He was cared for by his adoptive mother, AH, who took the view that the course of treatment recommended by his doctors exacerbated, rather than relieved, his symptoms. The PCT issued proceedings under the Mental Capacity Act to secure assessment and treatment of P. Expert evidence correctly applied the principles of s1 and the Code, and concluded the P lacked capacity to make the relevant decisions.

The case vividly demonstrated a disagreement between the patient's family and his doctors as to where his best interests lay. The 'closeness of the relationship'⁹⁹ between P and AH was seen as key to the 'real difficulty' in the case. In fact *four* difficulties were said to stem from this:

- (1) Real and unresolved doubt as to whether P's expressed views were his own or 'no more than simple adoption and repetition of his mother's views' when he would otherwise be malleable and co operative with expert attempts to improve the condition of his life;
- (2) Assessment required observation of him as an individual rather than 'as reported or recounted in the presence and under the influence of his mother' whose views were 'eccentric,

⁹⁸ [2008] EWHC 1403 at para.s 31-32.

⁹⁹ Para 19

misguided and...positively harmful' in the eyes of medical orthodoxy.

(3) Separation of P and his mother against their will would be highly distressing to both.

(4) The assessment task would be more difficult if P was reluctant and fearful, rather than willing and co operative.¹⁰⁰

Accordingly, the *doctors*¹⁰¹ were noted to have been concerned to achieve a course of treatment with which P's mother, and hence P himself, would co-operate. The *court* approach was to form its own view of P's best interests, on the basis of both the MCA Code para 5.62 *and* the 'balance sheet approach' of the inherent jurisdiction.¹⁰²

The court view was that P needed urgent admission. There were two possibilities – an immediate admission to Oak Rise, or a slightly delayed admission to Romford. AH had previously indicated a willingness to co- operate with Romford, which gave it a 'premium' that was 'obvious and desirable'.¹⁰³ Both the medics and the court were prepared to follow the option which AH preferred. It was grudging, couched in terms of firm expectation, and backed up by threats to take the alternative route if AH did not live up to her expressions of cooperation,¹⁰⁴ but it did give family views a decisive impact on treatment

¹⁰⁰ At first blush, this may suggest that the unusual accommodation offered to AH's views was motivated by fear that the proposed treatment could not be effective without her support. Such an interpretation does not, however, stand up to later judicial comment. Making fallback provisions to cover the possibility that AH would not live up to her promised co operation, Potter P noted that 'because of his physical condition and generally compliant temperament, it is unlikely that he will be physically resistant to being transported from his home to Oak Rise or to his assessment and treatment once there.' (para 25)

¹⁰¹ Para 19

¹⁰² Referred to at para 22. NB It was exactly the absence in the statute of any such balance sheet approach which Dunn et al had lamented. See n89 above.

¹⁰³ Para 23

¹⁰⁴ 'The whole basis upon which the experts are agreed that such a course, albeit involving a short delay, is nonetheless a desirable alternative to immediate admission at Oak Rise is that it will then involve consensuality rather than any degree of unwillingness, let alone coercion. Failing such consensuality, then it will be necessary to provide for P's immediate admission to Oak Rise, and for provision to be made as to the need for reasonable and proportionate

decisions. Not since *Re T*, the anomalous acceptance of a mother's refusal of her toddler's liver transplant, has the impact of family care on a patient's treatment been so acknowledged.

Is such acknowledgement attributable to the new statutory framework? It is impossible to say. Certainly there is no mention in the judgment of any enhanced recognition of family views, such as would not have been seen under the inherent jurisdiction. However, the medics were clearly taking their duties of consultation, and in particular the *context* of P's care, seriously – more seriously than the authorities under the inherent jurisdiction suggest.

Judicial accommodation of AH's preferences was firmly hedged about with provisions for securing P's treatment at Oak Rise in the event that AH did not live up to her promise of cooperation. Of necessity, this took the matter into the territory of the *Bournewood* gap. It was clearly a matter of irritation to the judge¹⁰⁵ that Counsel in the case had not considered the relationship between the *Bournewood* gap and the implementation of the Mental Capacity Act. He raised the authorities of *Sunderland v PS* and *Re GJ, NJ & BJ* himself, but considered that they begged, rather than answered, the question whether the powers of the Court of Protection under the Mental Capacity Act matched those of the inherent jurisdiction.¹⁰⁶

In order to answer his own question, the President claimed the support of Charles J's decision in *Surrey County Council v. MB* (a copy of which he was subsequently given). He took a whole raft of statutory provisions – sections 15(1)(c), 48, 16 and 17 – and paragraph 6.51 of the Code, and interpreted them as together entitling the Court of Protection to do under statute exactly what judges had previously done under inherent jurisdiction.¹⁰⁷

measures for securing the removal of P from his home for the purposes of in-patient assessment on the assumption that he and/or AH may not willingly comply." Para 23

¹⁰⁵ See para 26

¹⁰⁶ Section 5 of the MCA authorises acts of restraint if necessary to prevent harm to P; but section 6 specifically provides that the definition of restraint does not extend to deprivations of liberty within the meaning of Art 5(1) of the European Convention.

¹⁰⁷ Para 29

“Thus, where the facts so justify, and the immediate welfare interests of an incapacitated adult so dictate the court may, by a prior declaration in appropriate terms, render lawful an act of restraint under s6(1)-(4) of the Act which might otherwise amount to a deprivation of liberty under s6(5), thus bridging the ‘Bournewood Gap’”.

Contrary to Bartlett’s fears then, the indications of the first authorities of the statutory regime are that the inherent jurisdiction may not be such a wildcard after all. The declaratory jurisdiction may well become as little used as the legislature intended – as little used as the inherent jurisdiction in relation to children – genuinely a safeguard jurisdiction. If it does, it will be because the courts do not, after all, need to rely on a procedure of their own invention, when the judges can simply import the reasoning and the effect of that procedure into the new statutory provisions.

Conclusions

The new legislation owes much to the pre-existing common law. Judges led the calls for statutory reform; and case law established the principles on which it is based. The early indications are that the Mental Capacity Act is being interpreted and applied by judges in very much the same way as they interpreted and applied their old inherent jurisdiction.

The Act is patient-focussed, and families are conceived only as a subset of carers. The mechanism prescribed for the determination of ‘best interests’ gives families the roles of informant and opinion-holder, but not that of independent interest-bearer. However, the Act is also a practical response to the social phenomenon of an aging population increasingly cared-for in the community, and so it awards decision-making authority to whomsoever has the responsibility of putting a decision into effect.

In the more mundane, everyday matters the decision-maker may well be a family member, and the mechanism for determination of ‘best interests’ lends itself to

contextual decision-making. It is likely that the weight ascribed by family decision-makers to the various factors under consideration may be different to the weight ascribed to them by judges, leading to objectively different outcomes.

However, it is only the more mundane matters where family members are likely to be decision-makers. Significant matters, such as medical treatment decisions, will lie in others' hands. Then, when their own interests are likely to be significantly affected too, the right to be consulted for their views affords to families a disappointingly limited role.

Conclusions

Medical treatment disputes, and the issues at stake in their resolution, are undeniably complex. Patients and families are diverse in the needs, their capabilities and their expectations. At the end of our considerations, it is helpful to ask again those questions which first prompted our enquiry: how are medical treatment disputes to be resolved, and in particular what is the family's role?

What should be the role of the family?

As I have shown in chapter 1, patients and families are interdependent. Support from a family implies a better prognosis for the patient, and support of a patient implies a burden on the family. Such interdependence is the reason why we cannot, as Coggon suggests,¹ simply *hope* that what is best for the individual is also best overall², but should devise a system for medical dispute resolution which takes into account the interests of families as well as patients. Logically and morally, families have a claim for influence in medical decision-making. Their role *should* be one of active participation.

What is the most appropriate ethical basis for medical decision making ...

Affording an influential role to patients' families in the medical decision-making process is a challenge to the prevailing orthodoxy of patient autonomy. While autonomy's rise to ethical dominance served a vital purpose in the wake of tremendous social change, there is nothing immutable about it and society now has new needs. Modern health care provision leans heavily on 'care in the community', in which families play an essential part. In such a context, autonomy's exclusion of the family makes it an unsatisfactory ethic.

As we have seen in chapter 2, the most appropriate ethical framework for medical decision-making is one which not only protects patients' individual

¹ In 'Best Interests, Public Interest, and the Power of the Medical Profession' (2008) *Health Care Analysis* 219 at p220-221.

² We may recall from chapter 2 that the best interests of an individual does not necessarily satisfy a utilitarian approach: a small gain to the individual at great cost to others may be a less desirable outcome 'overall' than a lesser gain to the individual but at no cost to others.

liberties but also recognises the patient in context. Illness and disability limit our capacity to act as rationally autonomous decision-makers. In these circumstances, families are an anchor to our sense of self. The most appropriate ethic for medical decision making therefore combines deontological constraint as a minimum standard, and care as an ideal.

...and what does it suggest for the role of the family?

Such a combined ethic perceives the family as an intrinsic part of the patient's predicament, part of both the problem and the solution. The family role in resolving disputes is transformed from bystander, to significant character in the drama of the patient's life. Family considerations both extend and limit the narrative options. There is a tension inherent in such an ethical combination which decries easy answers to complex questions, but it does ensure that the decision-making process is informed from the perspectives of *both* the patient and the family, to the wider advantage of all.

What is the role historically afforded to families...

Having established a moral claim to influence, and an ethical framework within which to exercise it, considerations can turn to practical experience. As was shown in chapter 3, the role historically afforded to the family in medical treatment disputes was a long way short of our ideal. Analysis of decided cases³ revealed how judicial resolution of treatment disputes effectively limited family influence to polite hearing. The authority to determine disputes was exclusively reserved to judges, with a clear respect for medical expertise but no corresponding regard for familial relations. Families were useful sources of information and support, but family interests were not a relevant part of considerations.

³ By no means all such disputes end in litigation, but courts are powerful agents of authority. The approach they adopt to medical treatment disputes resonates beyond the individual cases which they determine so the role afforded to families by the court informs the role they can play in less contentious settings as well. As Muireann Quigley contends in 'Best Interests, the Power of the Medical Profession, and the Power of the Judiciary.' (2008) *Health Care Analysis* 233 at p 238, whereas a bad decision by a single doctor adversely affects his patients, a poor decision by a judge threatens by the doctrine of precedent to bind all doctors and all patients to bad decisions.

...and could it have been different?

As was shown in chapters 3 and 4, the limitations of the family role were determined not by principled consideration, but by legal accident. Whereas judicial powers extend to children by both modern statutory provision and by ancient inherent jurisdiction, over-zealous and poorly-considered statutory reform extinguished equivalent powers in respect of incapacitated adults. The courts were obliged to *invent* a jurisdiction to fill the lacuna and meet pressing social need. It was desperation, not idealism, which led the inventive powers of the House of Lords to settle on the old and vague doctrine of necessity, thereby creating a jurisdiction whose roots, like those of the jurisdiction in respect of children, are narrowly individualistic. The unsurprising result was that the principal guide to decision-making, namely the ‘best interests’ test, excluded families.

Yet there is nothing inevitable about a narrow understanding of ‘best interests’. Indeed over time and in non-linear fashion, according to the accidental facts of individual cases as is the nature of common law, the concept of best interests developed a broader focus. The family, however, remained peripheral because, as was shown in parts A to D of chapter 4, the core values by which such development was navigated were focused on other difficulties, like eugenics, or capacity, or the moral urge simultaneously to preserve life and recognise limits to its value.

The mechanism adopted for widening the understanding of ‘best interests’ was the ‘balancing exercise.’ The way to determine best interests was to put all constituent elements into the balance and see which end weighed most heavily. Once such an approach was adopted, it became possible to encompass more than strictly medical interests. Ultimately medical, emotional, cultural, spiritual and all other welfare interests came to be recognised.

Once such broad interests are admitted, it is difficult to see why the patient should be seen as anything other than a fully social being, enmeshed in

relationships which imply both benefit and burden. The family may have been marginal to the values which led to the adoption of the mechanism but it need not be marginal to its operation. If it can be recognised that the patient himself has interests which point in opposite directions, and that resolution may be achieved by a balancing exercise, it is a small step in logic to accept that competing interests of others can be accommodated in the same way. And so, a more influential role for families is possible.

Exactly that possibility was contemplated in *Re A*.⁴ The fact that it was not ever fully tested in court is more a testament to the hold on legal consciousness which autonomy and individualism have, then it is to the merits of the argument. It is not necessary to look very far afield to find an illustration of how such an approach might work. As was shown in part E of chapter 4, cases of paternity testing dispute after amendment⁵ of the Family Law Reform Act offer a working model⁶.

It would of course have required a shift in the judicial mindset to admit family interests into the balancing exercise: individualism is largely a judicial norm, which would be unsettled⁷. It would not, however, have required legislative reform. The legal machinery of the balancing exercise was already in place, and family interests would simply have been another factor to weigh in the scales. Sadly, any prospect of progress by judicial enlightenment is now lost. Whatever may have been, with the enactment of the Mental Capacity Act 2005 the inherent jurisdiction is now superceded by statute.

Why did the law change?

The pressures which led to legal reform were several, as we have seen in chapter 5. The judges themselves led the call for statutory reform, perceiving that

⁴ [2000] 1 FLR 549. See page 146 above, where it is noted that, in the context of male sterilisation the Court of Appeal consciously left open the possibility of argument based on third party interests.

⁵ By s82 of The Child Support, Pensions and Social Security Act 2000

⁶ See pages 234 – 248 above.

⁷ Thorpe LJ's enthusiasm in *Re A* is less typical than Butler-Sloss P's caution: see page 146 above.

judicial invention is an unsatisfactory basis for the law. Broader social realities of an ageing population and ever-growing healthcare costs ensured political engagement with the issue. Finally the *Bournewood* litigation exposed the law to the different jurisprudence of European Human Rights, and found it wanting. The Mental Capacity Act 2005 was the culmination of many forces, not all of them driven by patients and their families.

How did legislative reform affect the role of the family?

The effect of legal reform on the family role in resolving medical treatment disputes was mixed, as was shown in chapter 6. The Act only applies in respect of adults lacking capacity, so whole swathes of family care are completely unaffected. For those to whom the new legislation does apply, the starting point in respect of families is sadly familiar. The ‘five principles’ of the Mental Capacity Act make it clear that the focus of decision making is still narrowly individualistic – the patient alone, not the patient in the family.

On the other hand, the legislation has struck an attitude of support for informal decision making wherever responsibility falls, and in minor matters that will often be the family. An attitude of support in day to day care is something to be grateful for. Unfortunately it is also, as was demonstrated in chapter 6, the highwater mark of the legislation as far as families are concerned. What at first sight seems sympathetic to the claim for greater involvement in decision-making is, in fact, simply a reflection of the reality of ‘care in the community’ and the financial impossibility of any other policy approach.

The legislation’s true *disregard* of families is seen in the universal operation of the general authority. It goes *wherever* lies the responsibility for putting a decision into effect. In everyday matters, like outfits and aspirin, a family shouldering the burden of daily care will indeed have unprecedented freedom of action – but then so would anyone else performing the same tasks, even the unknown bank nurse of institutional care. A family *not* shouldering the burden of daily care is unaffected by choices of clothes and low-grade painkillers, so would be unlikely to seek influence there anyway. In more significant matters,

like surgery and sedation, medical professionals are involved. Doctors perform the operation and prescribe the medication, so *they* have the general authority under the Act to make such treatment decisions. Families are much more affected by issues of hip replacement or palliative care, but at the very point where the impact on them is greater, their ability to influence the decision recedes.

It is true that, even where they do not hold general authority to reach decisions, families ought to be consulted by decision-makers but, as we saw in chapter 6, the comfort in this is limited. Consultation does not imply influence. Families may give information about the patient, and their opinion of what is best for him, but they are not invited to express their own interests, still less expect them to be acted upon.

For families, and for the hope of securing for them an influential role in medical decision-making, the most troubling feature of the new legislation is revealed in the provisions for IMCAs. A new invention, to be appointed only where no family exists, IMCA are essentially a statutory substitute. Their invention implies acceptance that families have a valuable role to play, for otherwise there would be no point in arranging substitute. However, as was shown in chapter 6, their powers imply that families are at best taken for granted, at worst treated with suspicion. IMCAs have a *duty* of advocacy, a *right* to be consulted and a *right* of access to information. Families, on the other hand, can only give their opinion, are bound by rules of medical confidentiality and can expect to be consulted only ‘if it is practical and appropriate’ to do so (which allows medics to admit families as much as they choose, but also to disregard them as they think fit). The comparison suggests that more is expected of families than they are given credit for, and the underlying attitude to families is still one of mistrust.

So, what is the role of the family in medical treatment disputes?

It is unsatisfactory. After fundamental changes in the structures and policies of health and social care provision, after a major piece of legislation, *in law* the role of the family in medical treatment disputes is largely unchanged.

Appendix 1

The development of the best interest test over time and by treatment type

Treatment type					Case notes
Sterilisation	Life-saving treatment	Borderline capacity	Religion	Blood testing	
				✓	23 rd July 1970: Testing allowed <i>S v. S; W v. OS [1970] 3 All ER 107</i> : blood testing is part of the general protective duty only, not the custodial duty of courts, so child's interests are not pre-eminent.
✓					17 th September 1976: Treatment refused. <i>Re D [1976] Fam 185</i> : Patient aged just 11, and with capacity to marry. Mother's views rejected as social engineering. Doctor's support rejected as lacking impartiality
	✓				7 th August 1981: Treatment allowed <i>Re B (A Minor)(Wardship:Medical treatment) [1981] 1 WLR 1421</i> : if patient's life was still imponderable, failure to preserve it would be wrong.
		✓			17 th October 1985: Treatment allowed <i>Gillick v. West Norfolk & Wisbech AHA [1986] AC 112</i> : juvenile consent, at least to contraceptive treatment, possible.
✓					30 th April 1987: Treatment allowed <i>Re B (A Minor)(Wardship: Sterilisation) [1988] AC 199</i> : Patient aged 17. Her "right to reproduce" was dismissed because she would always lack ability to exercise it.
✓					1 st December 1987: Treatment allowed <i>Re M (Minor)(Wardship: Sterilisation)[1988] 2 FLR 497</i> : Patient aged 17. Eugenics disavowed but practical effect of foetal disability informed court assessment of patient's interests
✓					29 th June 1988: Treatment allowed <i>Re P (A Minor)(Wardship: Sterilisation)[1989] 1 FLR 182</i> : Court approval given just three weeks before patient's 18 th birthday, against OS request to postpone the decision.

	✓				20 th April 1989: Non-treatment allowed <i>Re C (A Minor)(Wardship: Medical Treatment) [1990] Fam 26</i> : Best interests may be to ease suffering rather than prolong life.
✓					24 th May 1989: Treatment allowed <i>Re F (Mental Patient: Sterilisation) [1990] 2 AC 1</i> : Treatment of incapacitated adult patient lawful if in her best interests. Sterilisation in a special category for which seeking court approval is good practice.
		✓	✓		21 st September 1990: Treatment allowed <i>Re E (A Minor)(Wardship: Medical Treatment) [1993] 1 FLR 386</i> : 15 year old found to lack competence to refuse life-saving treatment. Religious objections overridden.
	✓				19 th October 1990: Non-treatment allowed <i>Re J (A Minor)(Wardship: Medical Treatment) [1991] Fam 33</i> : presumption in favour of prolonging life is rebuttable. If patient is not terminally ill, determination of best interests includes account of pain and suffering if treatment is given, and may require a course of action which does not prevent death. Balancing exercise adopted.
✓					9 th April 1991: Treatment allowed <i>Re GF (Medical Treatment) [1992] 1 FLR 293</i> Sterilisation for purely therapeutic purposes does not require court sanction.
		✓			24 th July 1991: Treatment allowed <i>Re R (A Minor)(Wardship: Consent to Treatment) [1991] 3 WLR 592</i> : 15 year old lacked competence by reason of mental illness. (Consent as a key: court consent can override juvenile refusal.)
✓					24 th June 1992: Treatment allowed <i>Re W (An Adult: Sterilisation) [1993] 2 FCR 187</i> : Sterilisation lawful, even if risk of pregnancy small, because 'responsible body of medical opinion' in favour.
		✓			10 th July 1992: Treatment allowed <i>Re W (A Minor)(Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758</i> : 16 year old considered competent at 1 st Inst. but incompetent by reason of anorexia by CA. Court can override even a competent refusal. (Consent as a flak jacket.)
				✓	22 nd July 1992: Blood testing allowed <i>Re T (A Minor)(Blood Tests) [1992] 2 FCR 663</i> : Where both parents agree, the court would direct tests for DNA profiling.
			✓		28 th July 1992: Treatment allowed. <i>Re S (A Minor)(Medical Treatment) [1993] 1 FLR 376</i> : 4 year old boy treated with blood transfusions against the religious views of his parents.

		✓			30 th July 1992: Treatment allowed <i>Re T (Adult: Refusal of Treatment) [1993] Fam 95</i> : patient lacked capacity to make proper refusal because of medical misinformation (1 st inst) and undue influence (CA).
			✓		12 th October 1992: Treatment allowed <i>Re S (Adult: Surgical Treatment) [1993] 1 FLR 26</i> : patient's religious objections to Caesarean overridden, without any discussion of jurisdiction or competence.
		✓			27 th October 1992: Treatment allowed <i>South Glamorgan CC v. W & B [1993] 1 FLR 574</i> : If all other remedies fail, courts can still use inherent jurisdiction to override a 15 year old's competent refusal of treatment.
	✓				4 th February 1993: Non-treatment allowed <i>Airedale NHS Trust v. Bland</i> : CA – mere existence is not a benefit, but wide concept of best interests adopted. HL – clinical value of treatment supercedes interest considerations when patient has no medical interests.
				✓	5 th February 1993: Blood tests refused <i>Re F (A Minor)(Blood Tests: Parental rights) [1993] 3 WLR 369</i> : Court would not order blood tests against the wishes of the parent with sole responsibility since birth.
			✓		15 th March 1993: Treatment allowed <i>Re O (A Minor)(Medical Treatment) [1993] 2 FLR 149</i> : Premature baby treated with blood transfusions against the religious views of the parents.
			✓		24 th May 1993: Treatment allowed <i>Re R (A Minor)(Blood Transfusions)[1993] 2 FLR 757</i> : 10 month old baby treated with blood products against religious views of the parents, if no reasonable alternative and in life-threatening situations.
		✓			14 th October 1993: Treatment refused <i>Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290</i> : patient capacity confirmed, <u>after</u> medical crisis had passed.
✓					29 th October 1993: Treatment refused <i>Re LC (Medical Treatment: Sterilisation) [1997] 2 FLR 258</i> : even though patient in LA care, and had previously been sexually abused, the care now provided was so good that risk of pregnancy negligible.
				✓	7 th December 1993: Blood tests directed <i>Re G (A Minor)(Blood Tests) [1994] 1 FLR 495</i> : Court could and would direct testing even if the parent who was principal carer of the child made clear her intention not to comply with the direction.
	✓				14 th January 1994: Non-Treatment allowed <i>Frenchay Healthcare NHS Trust v. S [1994] 1 WLR 601</i> : Court should have ultimate power to review doctors' decisions.

				✓	23 rd May 1994: Blood tests not directed <i>Re CB (A Minor)(Blood Tests) [1994] 2 FLR 762</i> : Where evidence is cogent that child's primary carer will not comply, there is no point in making the direction.
		✓	✓		14 th June 1994: Treatment allowed <i>Re S (A Minor)(Consent to Medical Treatment) [1994] 2 FLR 1065</i> : 15 year old found not competent by reason of illness, failure to understand consequences, and maternal pressure (based on religious beliefs, which were overridden).
		✓			29 th November 1994: Treatment allowed <i>LB v. Croydon District Health Authority [1995] 1 FCR 332</i> : 1 st inst court found patient had capacity to refuse, but Mental Health Act overrode it. CA upheld statutory interpretation, but doubted capacity in any event.
				✓	28 th April 1995: <i>Re R (A Minor) (unreported)</i>
				✓	4 th July 1995: Blood tests refused <i>O v. L [1995] 2 FLR 930</i> : Husband had a good relationship with child and had applied for contact, which was likely to be in child's interests regardless of biological parentage. Mother's request for tests was motivated by wish to prevent contact.
				✓	5 th March 1996: Blood tests directed <i>Re H (A Minor)(Blood Tests: Parental Rights) [1997] Fam 89</i> : Intention of primary carer not to comply is not determinative of application for a direction for testing. Welfare does not dominate the decision.
	✓				26 th April 1996: Non-treatment allowed <i>Re R (Adult: Medical Treatment) [1996] 2 FLR 99</i> : Wide view of best interests – no need to 'strive officiously to keep alive'.
	✓				14 th June 1996: Treatment allowed <i>Re Y (Mental Incapacity: Bone Marrow Transplant) [1997] 2 FCR 172</i> : Bone marrow donation by severely handicapped 25 year old was in her best interests because it would save the life of her sister and therefore maintain supportive family links.
		✓			3 rd July 1996: Treatment allowed <i>Rochdale Healthcare (NHS) Trust v. C [1997] 1 FCR 274</i> : patient in labour lacked capacity on basis of inability to weigh information.
		✓			3 rd July 1996: Treatment allowed <i>Norfolk & Norwich Healthcare Trust v. W [1996] 2 FLR 613</i> : patient in labour lacked capacity on basis of inability to weigh information.

	✓				24 th October 1996: Non-treatment allowed <i>Re T(A Minor)(Wardship: Medical Treatment) [1997] 1 All ER 906</i> : best interests viewed 'on much broader grounds' than clinical assessment.
		✓			13 th December 1996: Treatment allowed <i>Re L (Patient: Non-consensual Treatment) [1997] 2 FLR 837</i> : patient in labour lacked capacity by reason of needle phobia.
		✓			18 th February 1997: Treatment allowed <i>Re MB (Medical Treatment) [1997] 2 FLR 426</i> : patient in labour lacked capacity by reason of needle phobia.
				✓	1 st May 1997: Blood tests directed <i>Re R (A Minor)(Blood Test: Constraint) [1998] 1 FLR 745</i> :
			✓		18 th November 1997: Non-treatment allowed <i>Re C (Medical Treatment) [1998] 1 FLR 384</i> : Doctors' view of baby's medical interests prevailed over parents' desire to pursue all possible treatment.
✓					29 th January 1998: Treatment refused <i>Re S (Adult: Sterilisation) [1999] 1 FCR 277</i> : The better carers protect the patient, the less reason for the court to sanction sterilisation.
		✓	✓		10 th June 1998: Treatment allowed <i>Re L (Medical Treatment: Gillick Competency) [1998] 2 FLR 810</i> : 14 year old found not competent by reason of insufficient information to make proper decision (and religious motivation? Religious views overridden)
✓					19 th June 1998: Treatment allowed <i>Re X (Adult Patient: Sterilisation) [1999] 3 FCR 426</i> : Court must consider risk of pregnancy without treatment; risk of harm in pregnancy; and range of alternative treatments, with associated risks.
		✓			30 th July 1998: Treatment first allowed but later found to be unlawful <i>St. George's Healthcare NHS Trust v. S [1999] Fam 26</i> : <u>After</u> medical crisis had been resolved, it was found that patient had at all times been competent.
		✓			15 th July 1999: Treatment allowed <i>Re M (Child: Refusal of Medical Treatment) [1999] 2 FCR 577</i> : 15 year old patient found not competent by reason of 'overwhelming' illness.
✓					10 th November 1999: Treatment allowed <i>Re ZM & OS (Sterilisation: Patient's Best Interests) [2001] 1 FLR 523</i> : Burden on carers easily inferred but not presented as a factor to be taken into account.

			✓		25 th November 1999: Treatment not allowed <i>Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision) [2000] 1 FLR 571</i> : where parents were not in agreement, circumcision was not in the best interests of 5 year old boy.
✓					20 th December 1999: sterilisation refused <i>Re A (Male Sterilisation) [2000] 1 FLR 549</i> : male patient. Interests of third parties, such as women he may potentially impregnate, left as an open question.
				✓	24 th January 2000: Remitted for consideration on the merits of directions. <i>Re O & J (Paternity: Blood Tests) [2000] 1 FLR 418</i> : The court had no jurisdiction to compel the parent with care of a child to give consent to blood testing.
✓					18 th May 2000: sterilisation refused <i>Re S (Adult Patient: Sterilisation) [2001] Fam 15</i> : CA criticised judge for giving too much weight to family concerns over strictly medical considerations.
	✓				5 th July 2000: Non-treatment allowed <i>A NHS Trust v. D [2000] 2 FLR 677</i> : Four principles apply – best interests of child are paramount, preservation of life save in exceptional circumstances, not prolonging life distinguished from terminating life, and courts cannot direct doctors to provide treatment against their professional judgment.
	✓				22 nd September 2000: Treatment allowed <i>Re A (Children)(Conjoined Twins: Surgical Separation) [2001] Fam 147</i> : Best interests can deal with competing interests.
				✓	10 th May 2001: Blood tests <i>Re T (A Child)(DNA Tests: Paternity) [2001] All ER 82</i> : It was in the child's best interests that the truth about paternity was known.
				✓	21 st March 2002: Blood tests ordered on appeal. <i>Re H & A [2002] EWCA Civ 383</i> : Trial judge gave insufficient weight to the importance of certainty.
		✓			22 nd March 2002: Non-treatment allowed <i>Re B (Adult: Refusal of Treatment) [2002] 2 FCR 1</i> : in non-emergency conditions, paralysed patient found to be competent to make her own treatment decisions.
		✓	✓		15 th August 2003: Treatment allowed <i>Re P (Minor) [2003] EWHC 2327</i> : 16 year old found not competent, with no clear explanation (religious motivation? Religious objections to treatment overridden)
			✓		30 th March 2004: Treatment not allowed. <i>Re S (Specific Issue Order: Religion: Circumcision) [2005] 1 FLR 236</i> : where parents were not in agreement, circumcision was not in the interests of 8 year old boy.

	✓				17 th September 2004: Reinstatement of treatment allowed <i>W Healthcare NHS Trust v. H</i> [2005] 1 WLR 834: Court decision must be based on assessment of best interests, not substituted judgment.
	✓				28 th July 2005: Declaration refused <i>R (Burke) v. GMC</i> [2005] QB 424: ‘Touchstone of intolerability’ rejected. Retreat from broad view of best interests.
	✓		✓		1 st September 2005: Withdrawal of treatment allowed <i>An NHS Trust v. X</i> [2005] EWCA Civ 1145: Court determination of best interests can assess differences of medical opinion. Religious views of patient and family overridden.
	✓				12 th October 2005: Non-treatment allowed <i>Portsmouth NHS Trust v. Wyatt</i> [2005] EWCA Civ 1181: Intolerability is a valuable guide for judges. Intellectual milestones set out.
		✓			23 rd January 2006: Treatment allowed <i>R (Axon) v. Sed. St. for Health</i> [2006] EWHC 37: Gillick affirmed for all types of treatment.
	✓				15 th March 2006: treatment withdrawal refused, non-escalation allowed <i>An NHS Trust v. MB</i> [2006] EWHC 507: Involvement of unimpeachable parents significant.
	✓				9 th May 2006: Treatment withdrawal allowed <i>Re K (A Child)(Medical Treatment: Declaration)</i> [2006] EWHC 1007: parents supported withdrawal and only distantly involved in care.
			✓		28 th July 2006: Treatment allowed <i>Ahsan v. University Hospitals Leicester NHS Trust</i> [2006] EWHC 2624: damages to be assessed at the higher level necessary to cover costs of treating pvs patient at home, in accordance with religious views.

Appendix 2

Best Interests: List of Cases (by order of last date of judgment)

I. Sterilisation

Re D [1976] Fam 185	17/09/1976
Re B (A Minor)(Wardship: Sterilisation) [1988] AC 199	30/04/1987
Re M (A Minor)(Wardship: Sterilisation) [1988] 2 FLR 497	01/12/1987
Re P(A Minor)(Wardship: Sterilisation) [1989] 1 FLR 182	29/06/1988
Re F (Mental Patient: Sterilisation) [1990] 2 AC 1	24/05/1989
Re GF (Medical Treatment) [1992] 1 FLR 293	09/04/1991
Re W (An adult: Sterilisation) [1993] 2 FCR 187	24/06/1992
Re LC (Medical treatment: Sterilisation) [1997] 2 FLR 258	29/10/1993
Re S (Adult: Sterilisation) [1999] 1 FCR 277	29/01/1998
Re X (Adult patient: Sterilisation) [1999] 3 FCR 426	19/06/1998
Re ZM & OS (Sterilisation: Patient's Best Interests) [2001] 1 FLR 523	10/11/1999
Re A (Male sterilisation) [2000] 1 FLR 549	20/12/1999
Re S (Adult patient: Sterilisation) [2001] Fam 15	18/05/2000

II. Life-saving Treatment

Re B (A Minor)(Wardship:Medical Treatment) [1981] 1 WLR 1421	07/08/1981
Re C (A Minor)(Wardship:Medical Treatment) [1990] Fam 26	20/04/1989
Re J (A Minor)(Wardship:Medical Treatment) [1991] Fam 33	19/10/1990
Airedale NHS Trust v. Bland [1993] 2 WLR 316	04/02/1993
Frenchay Healthcare NHS Trust v. S [1994] 1 WLR 601	14/01/1994
Re R (Adult: Medical Treatment) [1996] 2 FLR 99	26/04/1996
Re Y (Mental Incapacity: Bone Marrow Transplant) [1997] 2 FCR 172	14/06/1996
Re T (A Minor)(Wardship:Medical Treatment) [1997] 1 All ER 906	24/10/1996
A NHS Trust v. D [2000] 2 FLR 677	05/07/2000
Re A (Children)(Conjoined Twins: Surgical Separation) [2001] Fam 147	22/09/2000
W Healthcare NHS Trust v. H [2005] 1 WLR 834	17/09/2004
R (on the application of Burke) v. GMC [2005] QB 424	28/07/2005
An NHS Trust v. X [2005] EWCA Civ 1145	01/09/2005
Portsmouth NHS Trust v. Wyatt [2005] EWCA Civ 1181	12/10/2005
An NHS Trust v. MB [2006] EWHC 507	15/03/2006
Re K (A Child)(Medical Treatment: Declaration) [2006] EWHC 1007	09/05/2006
Re B (A Child)(Medical Treatment)[2008] EWHC 1996	10/06/2008
Re OT [2009] EWHC 633	19/03/2009

III. Borderline Capacity

Adults:

Re T (Adult: Refusal of Treatment) [1993] Fam 95	30/07/1992
Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290	14/10/1993
LB v. Croydon District Health Authority [1995] 1 FCR 332	29/11/1994
Tameside & Glossop Acute Services Trust v. CH [1996] 1 FLR 762	12/01/1996
Rochdale Healthcare (NHS) Trust v. C [1997] 1 FCR 274	03/07/1996
Norfolk & Norwich Healthcare Trust v. W [1996] 2 FLR 613	03/07/1996
Re L (Patient: Non-consensual treatment) [1997] 2 FLR 837	13/12/1996
Re MB (Medical Treatment) [1997] 2 FLR 426	18/02/1997
St. George's Healthcare NHS Trust v. S [1999] Fam 26	30/07/1998
Re B (Adult: Refusal of Treatment) [2002] 2 FCR 1	22/03/2002

Children:

Gillick v. West Norfolk & Wisbech AHA [1986] AC 112	17/10/1985
Re E (A Minor)(Wardship: Medical Treatment) [1993] 1 FLR 386	21/09/1990
Re R (A Minor)(Wardship: Consent to Treatment) [1991] 3 WLR 592	24/07/1991
Re W (A Minor)(Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758	10/07/1992
South Glamorgan CC v. W & B [1993] 1 FLR 574	27/10/1992
Re S (A Minor)(Consent to Medical Treatment) [1994] 2 FLR 1065	14/06/1994
Re L (Medical Treatment: Gillick Competency) [1998] 2 FLR 810	10/06/1998
Re M (Child: Refusal of Medical Treatment) [1999] 2 FCR 577	15/07/1999
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Re CB (A Minor)(Blood Tests) [1994] 2 FLR 762	23/05/1994
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Re H (A Minor)(Blood Tests: Parental Rights) [1997] Fam 89	05/03/1996
Re R(A Minor)(Blood Test: Constraint) [1998] 1 FLR 745	01/05/1997
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Re H & A [2002] EWCA Civ 383	21/03/2002

Appendix 3:

Chronology of Legislative and Litigation Progress

February 1995	Law Commission publishes its report on 'Mental Incapacity'
9 October 1997	<i>Bournewood</i> at First Instance
2 December 1997	<i>Bournewood</i> in the Court of Appeal
December 1997	Government publishes its consultation paper, 'Who Decides?'
25 June 1998	<i>Bournewood</i> in the House of Lords
October 1999	Government publishes its proposals, 'Making Decisions'
June 2002	Government publishes draft Mental Health Bill and consultation paper
June 2004	Mental Capacity Bill introduced in the Commons
October 2004	<i>Bournewood</i> in the European Court
March 2005	Government commenced consultation on response to <i>Bournewood</i>
7 April 2005	Mental Capacity Act received Royal Assent
29 June 2006	Government publishes 'Protecting the Vulnerable', a report of the consultation on the proposed response to <i>Bournewood</i>
19 July 2007	Mental Health Act received Royal Assent
1 April 2009	Deprivation of Liberty Safeguards (amendments to MCA by MHA) into effect

Appendix 4

Excerpt From Mental Capacity Act 2005

s4 Best interests

(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of—

- (a) the person's age or appearance, or
- (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3) He must consider—

- (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and
- (b) if it appears likely that he will, when that is likely to be.

(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable—

- (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- (c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of—

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (b) anyone engaged in caring for the person or interested in his welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which—

- (a) are exercisable under a lasting power of attorney, or
- (b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

(10) “Life-sustaining treatment” means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) “Relevant circumstances” are those—

- (a) of which the person making the determination is aware, and
- (b) which it would be reasonable to regard as relevant.

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